

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

519

CERTIFICATE OF DEATH

00519

Reg. Dist. No. 116

Item 9, Film G193 2-24-56 et

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Dorchester</u>		STATE <u>Maryland</u>		COUNTY <u>Dorchester</u>			
CITY (If outside corporate limits, write RURAL or and give nearest town) <u>13</u> TOWN <u>Cambridge</u>		LENGTH OF STAY (In this place) <u>15 mo.'s</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>RFD # 3, Cambridge, Md.</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Cambridge Maryland Hospital</u>				STREET ADDRESS (If rural give location) <u>1</u>			
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) <u>John Mc Gregor Barnes</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>Jan 1, 1956</u>			
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>married</u>	8. DATE OF BIRTH <u>3-5-1899</u>	9. AGE last birthday <u>56</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Physician</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Radiology</u>		11. BIRTHPLACE (State or foreign country) <u>Washington, D. C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Noble Barnes</u>				14. MOTHER'S MAIDEN NAME <u>Isabelle Mc Gregor</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>unk</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT & ADDRESS <u>RFD # 3, Mrs. John M. Barnes, Cambridge, Md.</u>			
18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH			
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH <u>420.1</u> IMMEDIATE CAUSE (A) <u>Coronary Infarction late & old</u>				<u>5 min. - 2 hrs.</u>			
ANTECEDENT CAUSE(S) DUE TO (B) <u>Arteriosclerotic Cardiovascular Disease</u>				<u>3 yrs.</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>Encephalomalacia</u>				<u>3 yrs.</u>			
11. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Pneumonia</u>							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21e. INJURY OCCURRED		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Sept 8, 1954</u> , to <u>Jan 1, 1956</u> , that I last saw the deceased alive on <u>Jan 1, 1956</u> , and that death occurred at <u>4:28</u> M. from the causes and on the date stated above.							
SIGNATURE <u>W. B. Barnes</u>				ADDRESS (Street, city, town, state) <u>Cambridge</u>		DATE SIGNED <u>1-1-56</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Cremation</u>		DATE THEREOF <u>1-1-56</u>		NAME OF CEMETERY OR CREMATORY <u>William Lee's Sons</u>		LOCATION (City, town, or county) (State) <u>Washington, D.C.</u>	
24. REC'D BY REGISTRAR DATE <u>Jan 9, 1956</u>		REGISTRAR'S SIGNATURE <u>John Thayer, R. D.</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Le Comte Funeral Service, Cambridge, Md.</u>			

11-11-11

CERTIFICATE OF DEATH

NAME OF DECEASED	AGE	SEX	RACE
DATE OF DEATH	PLACE OF DEATH	CITY	COUNTY
Cause of Death	Occupation	Marital Status	Religion

Signature of Physician	Signature of Registrar
Signature of Coroner	Signature of Burial Officer
Signature of Undertaker	Signature of Cemetery
Signature of Family	Signature of Friends
Signature of Church	Signature of Society
Signature of School	Signature of Other

BUREAU V. 5

JAN 6 1956

RECEIVED

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

520

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 00511

CERTIFICATE OF DEATH

Reg. Dist. No. 116

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Dorchester</u>	MARYLAND	STATE <u>Maryland</u> COUNTY <u>Dorchester</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Cambridge</u>	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Cambridge</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>9 School House Lane</u>		STREET ADDRESS (If rural give location) <u>9 School House Lane</u>	
3. NAME OF DECEASED: (First) (Middle) (Last) <u>Rachel</u> <u>Bishop</u>		4. DATE (Month) (Day) (Year) OF DEATH: <u>Jan</u> <u>21</u> <u>1956</u>	
5. SEX: <u>Female</u>	6. COLOR OR RACE: <u>Negro</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Single</u>	8. DATE OF BIRTH: <u>Sept. 29, 1900</u>
9. AGE last birthday <u>55</u> yrs.		10. BIRTHPLACE (State or foreign country): <u>Dorchester-Co-Md.</u>	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>laborer</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME: <u>James Bishop</u>		14. MOTHER'S MAIDEN NAME: <u>Rachel Bishop</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES (Yes, no, or unk.): <u>unk</u> (If Yes, give war or dates of service) <u>unk</u>		16. SOCIAL SECURITY NO.	
17. INFORMANT & ADDRESS:			
15. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
IMMEDIATE CAUSE (A) <u>Cardiac Decompensation</u>			
ANTECEDENT CAUSE (S) <u>Hypertensive Cardiovascular Disease</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.			
(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>Jan. 14, 1956</u> , to <u>Jan. 21, 1956</u> , that I last saw the deceased alive on <u>Jan. 21, 1956</u> , and that death occurred at <u>M.</u> from the causes and on the date stated above.			
SIGNATURE <u>J. Edwin Fassett</u>		DATE SIGNED <u>M.D.-227 Fine St-Camb., Md.-1-25-56</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>	DATE THEREOF <u>1-28-56</u>	NAME OF CEMETERY OR CREMATORY LOCATION (City, town, or county) (State) <u>Taylor's Island Cemetery Taylor's Island, Md.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>Jan. 27, 1956</u>	REGISTRAR'S SIGNATURE <u>John May, R.D.</u>	24. FUNERAL DIRECTOR ADDRESS <u>H.M. St. Clair, Jr., High St-Camb. Md</u>	

UNITED STATES GOVERNMENT

BUREAU V. 2

JAN 30 1956

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521

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <i>Dorchester</i>	MARYLAND	STATE <i>Maryland</i>	COUNTY <i>Dorchester</i>
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <i>Cambridge</i>	LENGTH OF STAY (in this place) <i>2 years</i>	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <i>Sussex</i>	X
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>Glenburne Nursing Home</i>		STREET ADDRESS (If rural give location)	<i>1</i>
3. NAME OF DECEASED: (Type or Print)		4. DATE OF DEATH:	
(First) <i>George</i> (Middle) <i>B.</i> (Last) <i>Blake</i>		(Month) <i>Jan.</i> (Day) <i>15</i> (Year) <i>1956</i>	
5. SEX: <i>male</i>	6. COLOR OR RACE: <i>white</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED: <i>widowed</i>	8. DATE OF BIRTH: <i>Nov 13, 1875</i>
9. AGE last birthday: <i>80</i> yrs.		IF UNDER 1 YEAR: Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life): <i>Farm Manager</i>		10B. KIND OF BUSINESS OR INDUSTRY: <i>Farm Manager</i>	
11. BIRTHPLACE (State or foreign country): <i>Talbot Co. Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>	
13. FATHER'S NAME: <i>Theodore Blake</i>		14. MOTHER'S MAIDEN NAME: <i>Lansie N. Berry</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.: <i>216-03-7504A</i>	
17. INFORMANT & ADDRESS: <i>Council Blake, Harmsburg Home</i>			
18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
420.1 IMMEDIATE CAUSE (A) <i>Coronary occlusion</i>			<i>4 days</i>
ANTECEDENT CAUSE (S): (B) <i>Coronary Heart Disease</i>			<i>2 yrs.</i>
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) <i>Peripheral Vascular Disease</i>			<i>2 yrs</i>
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION: <i>0</i>		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21C. WHERE DID (City or town) (County) (State)		21D. HOW DID INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
22. I hereby certify that I attended the deceased from <i>3/24, 1955</i> , to <i>1/15, 1956</i> ; that I last saw the deceased alive on <i>1/14, 1956</i> , and that death occurred at <i>4:35</i> A M, from the causes and on the date stated above.			
SIGNATURE <i>Lawrence Maryanor</i>		M. D. <i>Cambridge, Md</i> DATE SIGNED <i>1/17/56</i>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		NAME OF CEMETERY OR CREMATORY	
<i>Burial</i>		<i>Spring Hill</i>	
DATE REC'D BY LOCAL REGISTRAR <i>Jan. 17, 1956</i>		24. FUNERAL DIRECTOR ADDRESS <i>Maurice E. Newman & Son</i>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

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JAN 18 1956

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

522
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00513
Reg. Dist.

No. 116

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Dorchester</u>		MARYLAND		STATE <u>Md.</u>		COUNTY <u>Dorchester</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>13 TOWN Cambridge</u>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits write RURAL and give nearest town) <u>OR TOWN Cambridge</u>		<u>13</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>47 Cambridge Md. Hospital</u>				STREET ADDRESS (If rural, give location) <u>115 Pine St.</u>			
3. NAME OF DECEASED: (Type or Print) (First) (Middle) (Last) <u>LOTTIE C. BOGGS</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>Jan. 11, 1956</u>			
5. SEX: <u>Female</u>	6. COLOR OR RACE: <u>Negro</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>W</u>	8. DATE OF BIRTH: <u>Feb. 17, 1888</u>	9. AGE last birthday: <u>67</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country): <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME: <u>James W. Cornish</u>				14. MOTHER'S MAIDEN NAME: <u>Sophie Stewart</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY No.:		17. INFORMANT & ADDRESS: <u>Charles Cornish: Cambridge, Md.</u>			
18. MEDICAL CERTIFICATION							
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:						INTERVAL BETWEEN ONSET AND DEATH <u>24 hrs.</u>	
<u>812X</u> Immediate cause (a) <u>Subarachnoid Hemorrhage</u> DUE TO Antecedent cause(s) (b) <u>Shock</u> Diseases or conditions, if any, giving rise to the above cause DUE TO stating underlying cause last (c)							
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION: <u>2</u> 19b. MAJOR FINDING OF OPERATION:							
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21b. PLACE (Home, farm, factory, OF street, office bldg., etc.) <u>Injury Pine St.</u>		21c. (City or town) (County) (State) <u>Cambridge Dorchester Md.</u>			
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY <u>Jan. 11, 1956 8:30 AM</u>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		21f. HOW DID INJURY OCCUR? <u>Struck by a car.</u>			
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
SIGNATURE <u>John Moore</u>		M. D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <u>Jan. 16, 1956</u> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAM. <input type="checkbox"/>					
23. BURIAL, CREMATION, REMOVAL (Specify): <u>Burial</u>		DATE THEREOF <u>Jan. 15, 1956</u>		NAME OF CEMETERY OR CREMATORY <u>Bethel Cemetery</u>		LOCATION (City, town, or county) (State) <u>Cambridge, Md.</u>	
DATE REC'D BY LOCAL REG. <u>Jan. 15, 1956</u>		REGISTRAR'S SIGNATURE <u>John Moore</u>		24. FUNERAL DIRECTOR <u>Herbert H. St. Clair</u>		ADDRESS <u>Cambridge, Md.</u>	

BUREAU V. S.

JAN 18 1956

RECEIVED

523

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00514

CERTIFICATE OF DEATH

Reg. Dist. No. 116

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Dorchester</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Dorchester</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Cambridge</u>		LENGTH OF STAY (In this place) <u>Life</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Cambridge</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Cambridge Md Hospital</u>				STREET ADDRESS (If rural give location) <u>RFD #2</u>			
3. NAME OF DECEASED: (First) (Middle) (Last) <u>Russell</u> <u>Leon</u> <u>Brown</u>				4. DATE (Month) (Day) (Year) OF DEATH: <u>1</u> <u>17</u> <u>1956</u>			
5. SEX: <u>Male</u>	6. COLOR OR RACE: <u>Negro</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH: <u>January 1, 1901</u>	9. AGE last birthday <u>54</u> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Laborer</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>Food Packing</u>		11. BIRTHPLACE (State or foreign country): <u>Dorchester-Co-Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME: <u>Stephen Brown</u>				14. MOTHER'S MAIDEN NAME: <u>Emily Stevens</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>unk</u>		(If Yes, give war or dates of service) <u>unk</u>		17. INFORMANT & ADDRESS: <u>Elsie Brown, R.F.D.#2, Cambridge, Md.</u>			
16. SOCIAL SECURITY NO.							
18. MEDICAL CERTIFICATION							INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>Acute Myocardial infarction</u>							
ANTECEDENT CAUSE (B) <u>Coronary Heart Disease</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE, STATING UNDERLYING CAUSE LAST. (C) <u>Massive Pulmonary Edema</u>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION					20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State)		21D. HOW DID INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>					
22. I hereby certify that I attended the deceased from <u>Jan. 10, 1956</u> , to <u>Jan. 17, 1956</u> , that I last saw the deceased alive on <u>Jan. 17, 1956</u> , and that death occurred at <u>M.</u> , from the causes and on the date stated above.							
SIGNATURE <u>J. Edwin Fassett</u>		ADDRESS <u>227 Pine St-Camb., Md.-1-23-56</u>					
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>1-22-56</u>		NAME OF CEMETERY OR CREMATORY <u>Linas Road Cemetery</u>		LOCATION (City, town, or county) (State) <u>Linas Road-Dor-Md.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>Jan. 22, 1956</u>		REGISTRAR'S SIGNATURE <u>[Signature]</u>		24. FUNERAL DIRECTOR <u>H.M. St. Clair, Jr.</u>		ADDRESS <u>-High St-Camb., Md.</u>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

UNITED STATES OF AMERICA

192

BUREAU V. S.

JAN 26 1956

RECEIVED

00515

Reg. Dist.

537
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

No. 116

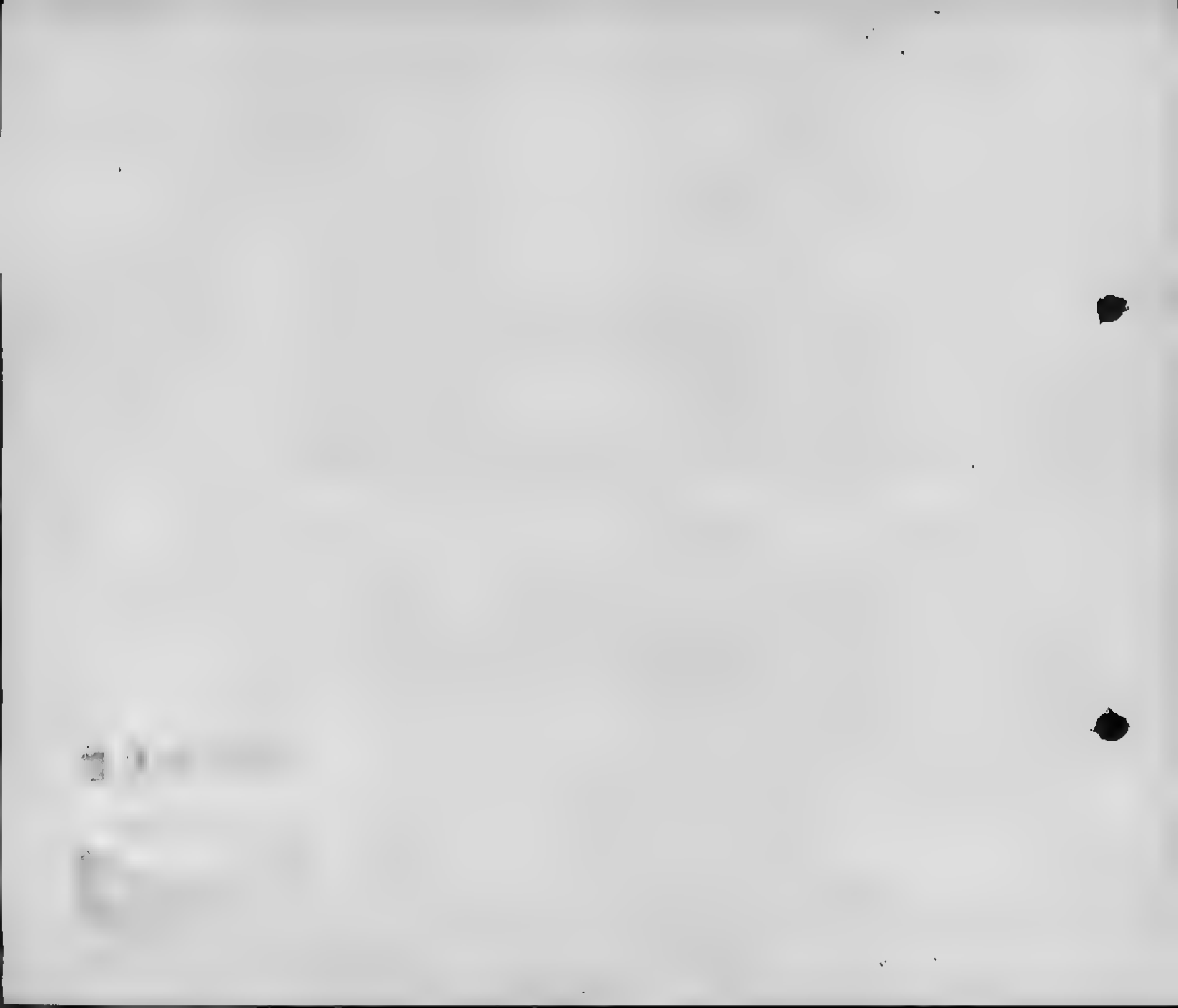
1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Dorchester</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Dorchester</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN <u>Cambridge, Rural</u>		LENGTH OF STAY (to this place) <u>2 years</u>		CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN <u>Cambridge, R.D. 1</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Cambridge, R.D. 1</u>				STREET ADDRESS (If rural, give location) <u>Cambridge R.D. 1</u>			
3. NAME OF DECEASED: (Type or Print)		(First) <u>Thomas</u>		(Middle) <u>Ryan</u>		(Last) <u>Coates</u>	
5. SEX: <u>Male</u>		6. COLOR OR RACE: <u>White</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Married</u>		8. DATE OF BIRTH: <u>Oct. 5, 1888</u>	
9. AGE last birthday: <u>67</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <u>Retired Machinist</u>		11. BIRTHPLACE (State or foreign country): <u>Buena Vista, Pa.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME: <u>Joseph Coates</u>				14. MOTHER'S MAIDEN NAME: <u>Hannah Logan</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>no</u>		16. SOCIAL SECURITY No.: <u>169-01-3449</u>		17. INFORMANT & ADDRESS: <u>R.D. 1</u> <u>Mrs. Bessie P. Coates, Cambridge, Md.</u>			

18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH: <u>420.1</u> Immediate cause (a) <u>Dorchester, Md.</u> DUE TO Antecedent cause(s) (b) Diseases or conditions, if any, giving rise to the above cause <u>DUE TO</u> stating underlying cause last (c)							
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION:				19b. MAJOR FINDING OF OPERATION:			
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>							
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY		21c. (City or town)		(County)	
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY		21e. INJURY OCCURRED While at Not while work <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input type="checkbox"/>, and find that death resulted from: Natural causes <input checked="" type="checkbox"/>, Accident <input type="checkbox"/>, Suicide <input type="checkbox"/>, Homicide <input type="checkbox"/>, Undetermined cause <input type="checkbox"/>. SIGNATURE <u>John M. [Signature]</u> M. D. ASSISTANT MEDICAL EXAM. <u>Jan.</u>							
23. BURIAL, CREMATION, REMOVAL (Specify):		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>Jan. 26, 1956</u>		<u>Mt. Vernon Cemetery</u>		<u>McKeesport, Pa.</u>	
DATE REC'D BY LOCAL REG.		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
<u>Jan. 23, 1956</u>		<u>John M. [Signature]</u>		<u>Kenneth R. Thomas</u>		<u>Cambridge, Md.</u>	
				<u>Hunter, Edmundson</u>		<u>Striffler</u>	
				<u>McKeesport, Pa.</u>			

MARGIN RESERVED FOR BINDING

VS. A15A - 5 - 53

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



MARYLAND

STATE DEPARTMENT OF HEALTH

524

CERTIFICATE OF DEATH

Reg. Dist. No. 116

1. PLACE OF DEATH COUNTY <u>Dorchester</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Dorchester</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Cambridge</u> LENGTH OF STAY (in this place) <u>1 day</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>East New Market</u> X	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Cambridge Maryland</u>		STREET ADDRESS (If rural, give location)	
3. NAME OF DECEASED (Type or Print) <u>Edith Seidler Collins</u>		4. DATE OF DEATH (Month) <u>1</u> (Day) <u>1</u> (Year) <u>1956</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED <u>Widowed</u>	8. DATE OF BIRTH <u>6/15/1880</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housework</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	9. AGE last birthday <u>75</u> yrs.
11. BIRTHPLACE (State or foreign country) <u>Chicago</u>		12. CITIZENSHIP OF WHAT COUNTRY <u>U.S.A.</u>	
13. FATHER'S NAME <u>Carl Seidler</u>		14. MOTHER'S MAIDEN NAME <u>Anna Schutzye</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT AND ADDRESS <u>German Seidler</u> <u>Washington D.C.</u>			

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		18. MEDICAL CERTIFICATION <u>Coronary occlusion</u>	INTERVAL BETWEEN ONSET AND DEATH <u>7 days</u>
420.1 Immediate cause (a)			
Antecedent cause(s)			
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			

19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>	
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, OF office bldg., etc.)		(CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>		HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from 12/31, 1955, to 1/1, 1956, that I last saw the deceased alive on 12/31, 1955, and that death occurred at 12:30 m., from the causes and on the date stated above.

SIGNATURE <u>James Manyano M.D.</u>		ADDRESS <u>Cambridge, Md.</u>		DATE SIGNED <u>1/4/56</u>	
23. BURIAL, CREMATION OR REMOVAL (Specify) <u>Burial</u>		DATE <u>1/3/56</u>		NAME OF CEMETERY OR CREMATORY <u>East New Market Md.</u>	
LOCATION (City, town, or county) (State) <u>East New Market Md.</u>		24. FUNERAL DIRECTOR <u>Luick S. Meloughby</u>		ADDRESS <u>East New Market, Md.</u>	
DATE REC'D BY LOCAL REG. <u>Jan 3, 1956</u>		REGISTRAR'S SIGNATURE <u>John Hall, Jr.</u>			

BUREAU V. S.

1914

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

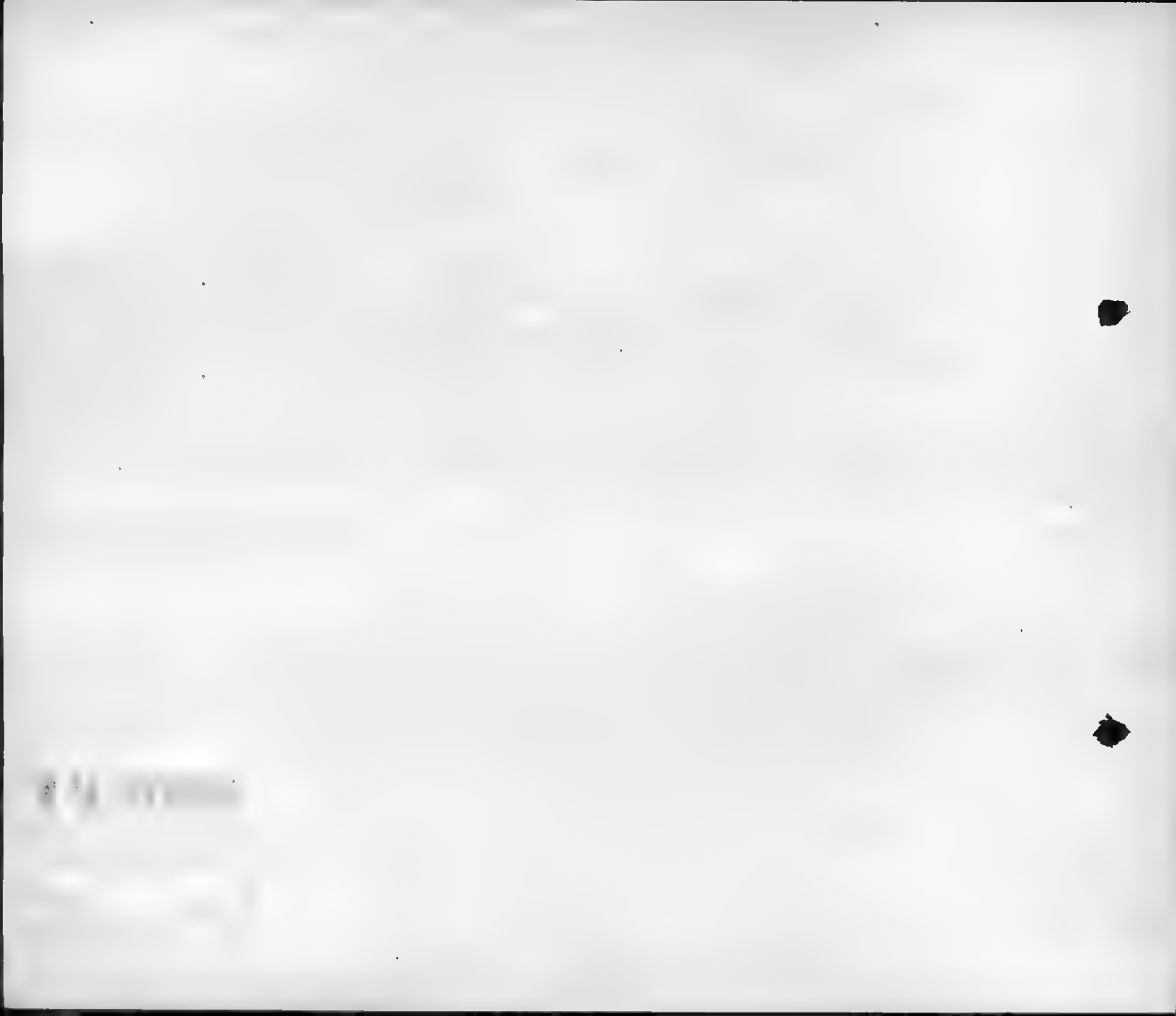
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00517

CERTIFICATE OF DEATH

Reg. Dist. No. 116

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Dorchester</u>	MARYLAND	STATE <u>Maryland</u> COUNTY <u>Dorchester</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Smithsville</u>	LENGTH OF STAY (In this place)	CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Smithsville</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural give location)	
3. NAME OF DECEASED: (Type or Print) <u>Fred</u> <u>Lincoln</u> <u>Cornish</u>		4. DATE (Month) (Day) (Year) OF DEATH: <u>Jan.</u> <u>27</u> , <u>1956</u>	
5. SEX: <u>Male</u>	6. COLOR OR RACE: <u>Negro</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH: <u>Feb. 8</u> , <u>1886</u>
9. AGE last birthday <u>69</u> yrs.		10. BIRTHPLACE (State or foreign country): <u>Dorchester County, Md.</u>	
11. BIRTHPLACE (State or foreign country): <u>Dorchester County, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME: <u>Adam Cornish</u>		14. MOTHER'S MAIDEN NAME: <u>Annie Wilson</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>207-07-1429</u>		17. INFORMANT & ADDRESS: <u>Annie Ward, Smithsville, Dor. Co., Md.</u>	
18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
44 2X IMMEDIATE CAUSE (A) <u>Stroke</u>			
ANTECEDENT CAUSE (B) <u>Systemic arteriosclerosis</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.			
(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21C. WHERE DID (City or town) (County) (State)		21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	
21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>Jan 27</u> , 195 <u>6</u> , to <u>Jan 27</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>Jan 27</u> , 195 <u>6</u> , and that death occurred at <u>7:00</u> M. from the causes and on the date stated above.			
SIGNATURE <u>James H. Thompson</u>		ADDRESS <u>Cambridge, Md.</u>	
DATE SIGNED <u>Jan 30 1956</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>1/31/1956</u>	
NAME OF CEMETERY OR CREMATORY <u>Smithsville Cemetery</u>		LOCATION (City, town, or county) (State) <u>Smithsville, Maryland</u>	
DATE REC'D BY LOCAL REGISTRAR <u>Jan 30, 1956</u>		REGISTRAR'S SIGNATURE <u>John H. D.</u>	
24. FUNERAL DIRECTOR <u>H.M. St. Clair, Jr.</u>		ADDRESS <u>Cambridge, Md.</u>	



525

CERTIFICATE OF DEATH

Reg. Dist. No. 116

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Dorchester</u>	MARYLAND	STATE <u>Maryland</u> COUNTY <u>Dorchester</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>Cambridge</u>	LENGTH OF STAY (in this place) <u>Sev.mos.</u>	CITY(If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Cambridge</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>72 Washington Street</u>		STREET ADDRESS (If rural give location) <u>72 Washington Street</u>	
3. NAME OF DECEASED: (First) (Middle) (Last)		4. DATE (Month) (Day) (Year)	
(Type or Print) <u>Rev. James A. Fassett</u>		OF DEATH: <u>Jan. 17 1956</u>	
5. SEX: <u>Male</u>	6. COLOR OR RACE: <u>Negro</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH: <u>Aug. 13, 1891</u>
9. AGE last birthday <u>64</u> yrs. <u>5</u> Months <u>4</u> Days <u></u> Hours <u></u> Min.			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Minister</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>Ministry</u>	11. BIRTHPLACE (State or foreign country): <u>Berlin, Maryland</u>
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
13. FATHER'S NAME: <u>Joshua Fassett</u>		14. MOTHER'S MAIDEN NAME: <u>Aralanta Showell</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>None</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT & ADDRESS: <u>Josephine Fassett, Berlin, Md.</u>			
18. MEDICAL CERTIFICATION			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			INTERVAL BETWEEN ONSET AND DEATH
(A) <u>Generalized carcinomatosis</u>			<u>3 mos.</u>
IMMEDIATE CAUSE DUE TO			
ANTECEDENT CAUSE (S):			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.			<u>Unknown</u>
(B) <u>Carcinoma colon, right</u>			
DUE TO			
(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION: <u>Sept. 1, 1955</u>		19B. MAJOR FINDINGS OF OPERATION: <u>Carcinoma of colon, right with metastases</u>	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.	
21C. WHERE DID (City or town) (County) (State)		INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Jan 8, 1956</u> to <u>Jan. 17, 1956</u> that I last saw the deceased alive on <u>Jan. 8, 1956</u> , and that death occurred at <u>11:00 A.M.</u> from the causes and on the date stated above.			
SIGNATURE <u>Lavinia M. Burdette</u>		M.D. <u>City Office Bldg., Cambridge, Md.</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>Jan. 22, '56</u>	NAME OF CEMETERY OR CREMATORY <u>Flowers St. Cemetery</u>
LOCATION (City, town, or county) (State) <u>Berlin, Maryland</u>			
DATE REC'D BY LOCAL REGISTRAR <u>January 23, 1956</u>		REGISTRAR'S SIGNATURE <u>John Chase, R.D.</u>	24. FUNERAL DIRECTOR ADDRESS <u>H. M. St. Clair, Jr., Cambridge, Md.</u>

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

8 11 10

10 11 10

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

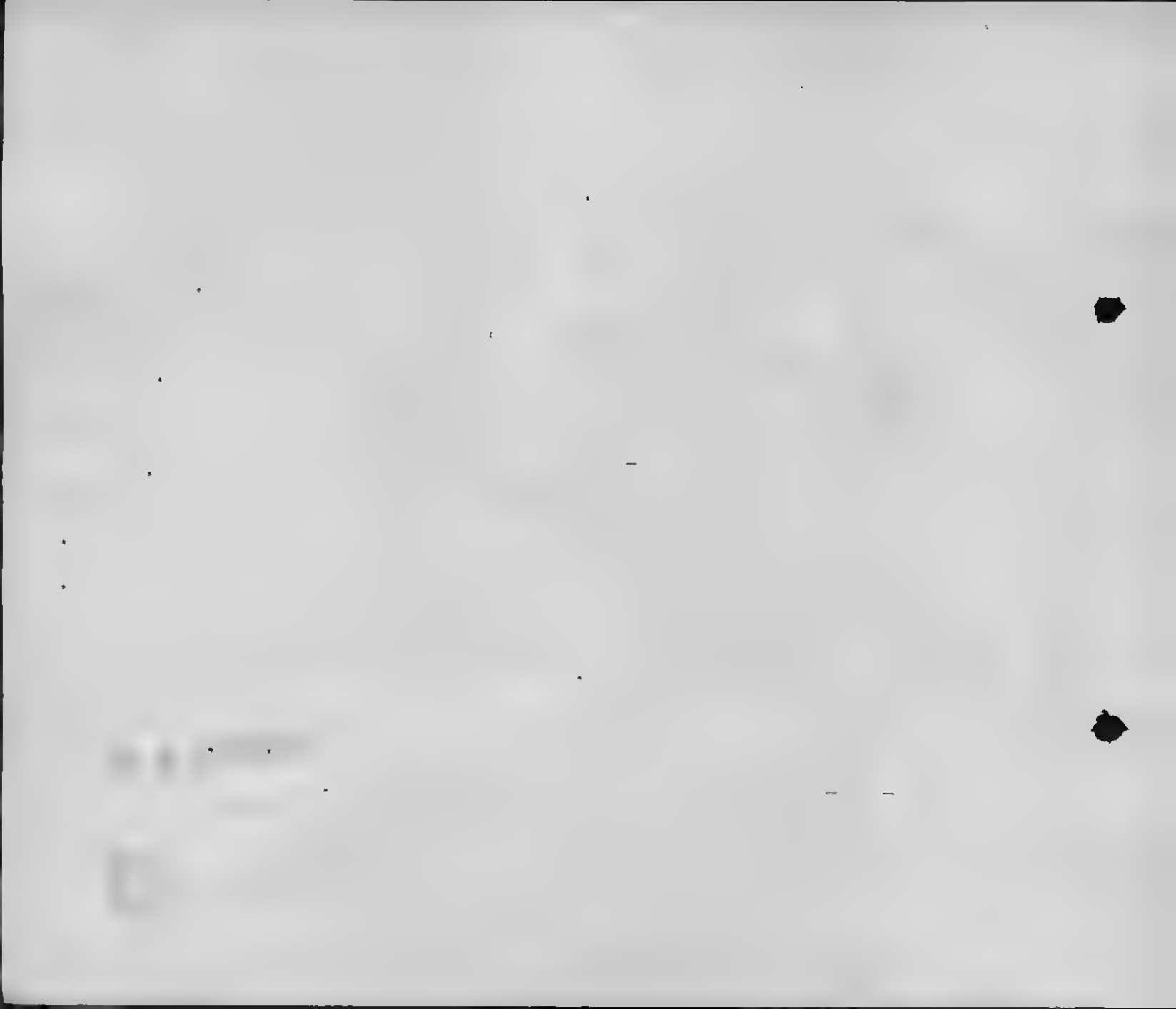
533

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH No. 116

00519
Reg. Dist.

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY Dorchester		MARYLAND		STATE Maryland COUNTY Dorchester			
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits write RURAL and give nearest town)			
TOWN Cambridge		4 Mo.		TOWN Church Creek			
HOSPITAL OR INSTITUTION OR STREET ADDRESS Eastern Shore State Hospital				STREET ADDRESS (If rural, give location)			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE OF DEATH (Month) (Day) (Year)			
Joseph S Fitzhugh				Jan. 7 19 56			
5. SEX: M		6. COLOR OR RACE: White		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): M		8. DATE OF BIRTH: Nov 26, 1882	
9. AGE last birthday: 73 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): Waterman		11. BIRTHPLACE (State or foreign country): Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME: Joseph Fitzhugh				14. MOTHER'S MAIDEN NAME: Amanda Dean			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No		16. SOCIAL SECURITY No.: -		17. INFORMANT & ADDRESS: Records Eastern Shore State Hosp.			
18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:							
Immediate cause (a) Pneumonia				1 wk.			
DUE TO							
Antecedent cause(s) (b) Fracture left femur				2 mo.			
Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (c)							
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. Ch. brain syndrome				?			
19a. DATE OF OPERATION: 0		19b. MAJOR FINDING OF OPERATION:		20. AUTOPSY? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input checked="" type="checkbox"/>		21b. PLACE (Home, farm, factory, OF street, office bldg., etc.) INJURY Hospital		21c. (City or town) (County) Cambridge Dor. Md.		(State)	
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY 11-10-55 2p.m.		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		21f. HOW DID INJURY OCCUR? Fell to floor.			
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
SIGNATURE James M. Mc...		M. D.		CHIEF MEDICAL EXAMINER		DATE SIGNED 1/8/56	
23. BURIAL, CREMATION, REMOVAL (Specify): BURIAL		DATE THEREOF 1-16-56		NAME OF CEMETERY OR CREMATORY DORCHESTER MEM. PK.		LOCATION (City, town, or county) (State) Cambridge Md.	
DATE REC'D BY LOCAL REG. Jan. 16, 1956		REGISTRAR'S SIGNATURE John Shaw		24. FUNERAL DIRECTOR McCampbell		ADDRESS FUNERAL SERVICE Cambridge, Md.	

Pr J.D.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

528

00520

Reg. Dist.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

No. 135

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Worcester</u>		MARYLAND		STATE <u>Md.</u>		COUNTY <u>Worcester</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN <u>Cambridge</u>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN <u>Cambridge</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>183 Washington St.</u>				STREET ADDRESS (If rural, give location) <u>183 Washington St.</u>			
3. NAME OF DECEASED: (Type or Print) <u>SARAH</u>				4. DATE OF DEATH <u>2/6/1956</u>			
5. SEX: <u>Female</u>				6. COLOR OR RACE: <u>White</u>			
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Single</u>				8. DATE OF BIRTH: <u>April 25, 1899</u>			
9. AGE last birthday: <u>56</u> yrs.				10. IF UNDER 1 YEAR: Months <u>2</u> Days <u>6</u> Hours <u>19</u> Min.			
11. BIRTHPLACE (State or foreign country): <u>Worcester County, Md.</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>			
13. FATHER'S NAME: <u>Jerry Paine</u>				14. MOTHER'S MAIDEN NAME: <u>Esther Paine</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>No</u>				16. SOCIAL SECURITY No.: <u>01-20-7134</u>			
17. INFORMANT & ADDRESS: <u>R. James Travers: RD #3, Cambridge,</u>							
18. MEDICAL CERTIFICATION							
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:						INTERVAL BETWEEN ONSET AND DEATH	
Immediate cause (a) <u>Coronary Atherosclerosis</u> DUE TO						?	
Antecedent cause(s) (b) <u>giving rise to the above cause</u> DUE TO							
stating underlying cause last (c)							
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION: <u>2/6/1956</u>				19b. MAJOR FINDING OF OPERATION:			
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>							
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		21b. PLACE (Home, farm, factory, OF street, office bldg., etc.) INJURY		21c. (City or town) (County) (State)			
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
SIGNATURE <u>J. J. Paine</u>				DATE SIGNED <u>1-9-1956</u>			
23. BURIAL, CREMATION, REMOVAL (Specify): <u>burial</u>				24. FUNERAL DIRECTOR ADDRESS			
DATE REC'D BY LOCAL REG. <u>Jan 9, 1956</u>		REGISTRAR'S SIGNATURE <u>J. J. Paine</u>		LOCATION (City, town, or county) <u>Cambridge, Md.</u>			
25. NAME OF CEMETERY OR CREMATORY <u>Bethel Cemetery</u>							



527

CERTIFICATE OF DEATH

Reg. Dist. No. 116

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <i>Dorchester</i>		MARYLAND		STATE <i>Md</i>		COUNTY <i>Dorchester</i>	
CITY (If outside corporate limits, write RURAL or end give nearest town) <i>Cambridge</i>		LENGTH OF STAY (In this place) <i>1 day</i>		CITY (If outside corporate limits, write RURAL and give nearest town) <i>Cambridge</i>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>Cambridge-hrd Hospital</i>				STREET ADDRESS (If rural give location) <i>207 Academy St.</i>			
3. NAME OF DECEASED (First) <i>William</i> (Middle) (Last) <i>Fries</i>				4. DATE OF DEATH (Month) <i>Jan</i> (Day) <i>25</i> (Year) <i>1956</i>			
5. SEX <i>M</i>	6. COLOR OR RACE <i>White</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <i>widowed</i>	8. DATE OF BIRTH <i>MAY 3 1988</i>		9. AGE last birthday <i>67</i> yrs.	IF UNDER 1 YEAR Months <i></i> Days <i></i> Hours <i></i> Min. <i></i> IF UNDER 24 HRS. Hours <i></i> Min. <i></i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>retired fishing station owner</i>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>NEW JERSEY</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>
13. FATHER'S NAME <i>James Fries</i>				14. MOTHER'S MAIDEN NAME <i>Ethel Graham</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO. <i>220-07-0808</i>		17. INFORMANT & ADDRESS <i>Richard G. Fries Cambridge, Md.</i>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
4. IMMEDIATE CAUSE (A) <i>Coronary occlusion</i>				INTERVAL BETWEEN ONSET AND DEATH <i>1 day</i>			
ANTECEDENT CAUSE(S) DUE TO (B) <i>Coronary Heart Disease</i>				<i>1 yr</i>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <i>Atherosclerotic Heart Disease</i>				<i>1 yr</i>			
11. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (M.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <i>1/25</i>, 19<i>56</i>, to <i>1/25</i>, 19<i>56</i>; that I last saw the deceased alive on <i>1/25</i>, 19<i>56</i>, and that death occurred at <i>12:15</i> P.M. from the causes and on the date stated above.							
SIGNATURE <i>Lawrence Maryanov</i> M.D. <i>Cambridge, Md.</i>				DATE SIGNED <i>1/27/56</i>			
23. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		DATE THEREOF <i>1/28/56</i>		NAME OF CEMETERY OR CREMATORY <i>Offord Cemetery</i>		LOCATION (City, town, or county) (State) <i>Offord Md.</i>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <i>John Mace, Jr.</i>		25. FUNERAL DIRECTOR'S SIGNATURE <i>Malcolm E. Leonard</i>		ADDRESS <i>Easton Md.</i>	
DATE <i>Jan. 31, 1956</i>							

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

RECEIVED
FEB 1

540 CERTIFICATE OF DEATH

Reg. Dist. No. 110

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Dorchester</u> MARYLAND	CITY (If outside corporate limits, write RURAL and give nearest town) <u>Federalsburg - Rural</u>	STATE <u>Maryland</u> COUNTY <u>Dorchester</u>	CITY (If outside corporate limits, write RURAL and give nearest town) <u>Federalsburg - Rural</u>
OR TOWN <u>Federalsburg - Rural</u>	LENGTH OF STAY (In this place) <u>Life</u>	OR TOWN <u>Federalsburg - Rural</u>	OR TOWN <u>Federalsburg - Rural</u>
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Near Cokesbury</u>		STREET ADDRESS (If rural give location) <u>Near Cokesbury</u>	
3. NAME OF DECEASED: (First) (Middle) (Last)		4. DATE (Month) (Day) (Year)	
<u>Perry Lee Hackett</u>		OF DEATH: <u>January 10 1956</u>	
5. SEX: <u>Male</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Married</u>	8. DATE OF BIRTH: <u>April 6, 1873</u>
9. AGE last birthday <u>82</u> yrs. Months Days Hours Min.		10. BIRTHPLACE (State or foreign country): <u>Dorchester Co., Maryland</u>	
11. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME: <u>Perry G. Hackett</u>		14. MOTHER'S MAIDEN NAME: <u>Priscilla Tull</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>No</u> (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT & ADDRESS: <u>Mrs. Alice L. Hackett, Seaford, Del. RFD</u>			
18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
IMMEDIATE CAUSE <u>420.0</u>			
ANTECEDENT CAUSE (S)			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.			
(A) <u>Arteriosclerotic Heart Disease</u>		<u>6 yrs -</u>	
(B) <u>Coronary atherosclerosis with myocardial infarction</u>		<u>16 months</u>	
(C) <u>Myocardial failures</u>		<u>1 mo.</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION	
1			
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, street, office bldg., etc.)	
		21C. WHERE DID (City or town) (County) (State)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Mar</u> , 1949, to <u>Jan 10</u> , 1956, that I last saw the deceased alive on <u>Jan 9</u> , 1956, and that death occurred at <u>4:40 A</u> M, from the causes and on the date stated above.			
SIGNATURE <u>J. Heland Jr. M.D.</u>		ADDRESS <u>Seaford, Delaware</u>	
DATE SIGNED <u>Jan. 10, 1956</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>Jan. 12, 1956</u>	
NAME OF CEMETERY OR CREMATORY <u>Cokesbury Cemetery</u>		LOCATION (City, town, or county) (State) <u>Near Federalsburg, Md.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>Jan 12-1956</u>		REGISTRAR'S SIGNATURE <u>Charles Hastings</u>	
24. FUNERAL DIRECTOR <u>J.J. Frampton and Son, Federalsburg, Md.</u>		ADDRESS	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

JAN 17 1951

RECEIVED

528

CERTIFICATE OF DEATH

Reg. Dist. No. 16

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Dorchester</u>	MARYLAND	STATE <u>Maryland</u>	COUNTY <u>Dorchester</u>
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Cambridge</u>	LENGTH OF STAY (in this place) <u>1 week</u>	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Bishops Head</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Cambridge Md. Hospital</u>		STREET ADDRESS (If rural give location)	
3. NAME OF DECEASED:		4. DATE (Month) (Day) (Year)	
(First) <u>GRACE</u>	(Middle) <u>PHILLIPS</u>	(Last) <u>JOHNSON</u>	OF DEATH: <u>Jan 17 1956</u>
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>8-28-1889</u>
9. AGE last birthday <u>66</u> yrs.		10. IF UNDER 1 YEAR	11. IF UNDER 24 HRS.
		Months	Days
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):		10B. KIND OF BUSINESS OR INDUSTRY: <u>Seafood</u>	11. BIRTHPLACE (State or foreign country): <u>Hoopers Island, Maryland</u>
13. FATHER'S NAME: <u>John R. Phillips</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY NO. <u>218-01-5253</u>	
(If Yes, give war or dates of service)		17. INFORMANT & ADDRESS: <u>Mr. Herman Tolley Bishops Head, Md.</u>	
18. MEDICAL CERTIFICATION			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE		(A) <u>Diffuse Peritonitis</u> <u>7 days.</u>	
ANTECEDENT CAUSE (S):		(B) <u>Perforation of Sigmoid Colon.</u> <u>7 days.</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE, STATING UNDERLYING CAUSE LAST.		(C) <u>Carcinoma of Sigmoid.</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID (City or town) (County) (State)		21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	
21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>1/10</u> , 19 <u>56</u> , to <u>1/17</u> , 19 <u>56</u> , that I last saw the deceased <u>alive on</u> <u>1/17</u> , 19 <u>56</u> , and that death occurred at <u>3 A</u> M, from the causes and on the date stated above.			
SIGNED <u>W. H. Banks</u>		ADDRESS <u>Cambridge Md</u>	
DATE SIGNED <u>1/18-1956</u>		M. D. <u>Cambridge Md</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>1-19-1956</u>	
NAME OF CEMETERY OR CREMATORY <u>St. Thomas Church Yard</u>		LOCATION (City, town, or county) (State) <u>Bishops Head, Dor. Md.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>Jan 19, 1956</u>		REGISTRAR'S SIGNATURE <u>John Nae, M.D.</u>	
24. FUNERAL DIRECTOR		ADDRESS <u>LeCompte Funeral Service Cambridge, Md.</u>	

MARGIN RESERVED FOR BINDING

VS. A15 — 10 - 53

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



MARYLAND

541

STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

Reg. Dist. No. 116

1. PLACE OF DEATH COUNTY <u>Dorchester</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Dor.</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Church Creek</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Church Creek, Md.</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural, give location)	
3. NAME OF DECEASED (Type or Print) <u>Carl</u> (First) <u>Neal</u> (Middle) <u>Jones</u> (Last)		4. DATE OF DEATH (Month) <u>1</u> (Day) <u>29</u> (Year) <u>1956</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED <u>Widowed</u>	8. DATE OF BIRTH <u>6/11/1873</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Carpenter, Ret.</u>		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE last birthday <u>82</u> yrs.
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13. FATHER'S NAME <u>Thomas Jones</u>		14. MOTHER'S MAIDEN NAME <u>Stelen Richardson</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT AND ADDRESS <u>Hullie Jones</u> <u>Church Creek, Md.</u>			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

420.0

Immediate cause (a)..... Uremia

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c).....

Arteriosclerotic heart disease
Cerebral hemorrhage

INTERVAL BETWEEN ONSET AND DEATH

3 days5 yrs.
8 mos.

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☐

21. ACCIDENT (Specify) SUICIDE HOMICIDE	PLACE (Home, farm, factory, street, office bldg., etc.) INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from 7-7- 1953, to 1-29- 1956 that I last saw the deceasedalive on 1-7-56 1956, and that death occurred at 8:15 a.m. from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION, REMOVAL (Specify)	DATE	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
<u>Burial</u>	<u>1/31/56</u>	<u>Washington</u>	<u>Durlock</u>	<u>Md.</u>

DATE REC'D BY LOCAL REG.

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

Feb. 1, 1956J. H. V. Lee, M.D.East New Market, Md.

100-100000

100-100000

529

CERTIFICATE OF DEATH

Reg. Dist. No. 116

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Dorchester</u>	MARYLAND	STATE <u>Maryland</u>	COUNTY <u>Dorchester</u>
CITY (If outside corporate limits, write RURAL OR and give nearest town)	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town) OR	
TOWN <u>Cambridge</u>	<u>Life</u>	TOWN <u>Cambridge</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>9 Bethel Street</u>		STREET ADDRESS (If rural give location) <u>9 Bethel Street</u>	
3. NAME OF DECEASED:		4. DATE (Month) (Day) (Year)	
(First) <u>Samuel</u>	(Middle)	(Last) <u>Locks</u>	OF DEATH: <u>1</u> <u>2</u> <u>19 56</u>
5. SEX: <u>Male</u>	6. COLOR OR RACE: <u>Negro</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widower</u>	8. DATE OF BIRTH: <u>Nov-15-1875</u>
9. AGE last birthday <u>80</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>unemployed</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>- - -</u>	
11. BIRTHPLACE (State or foreign country): <u>Dor-County-Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME: <u>Jeremia Locks</u>		14. MOTHER'S MAIDEN NAME: <u>Lizzie Locks</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>unk</u> (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>unk</u>	
17. INFORMANT & ADDRESS: <u>Annie Kane, Cambridge, Maryland</u>			
18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
420.0 IMMEDIATE CAUSE (A) <u>Cardiac Decompensation</u>			
ANTECEDENT CAUSE (B) <u>Hypertensive Arteriosclerotic Heart Disease</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory OF INJURY street, office bldg., etc.)	
		21C. WHERE DID (City or town) (County) (State)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>Mar. 29, 1954</u> to <u>Jan. 2, 1956</u> , that I last saw the deceased alive on <u>Jan. 2, 1956</u> , and that death occurred at <u>M.</u> , from the causes and on the date stated above.			
SIGNATURE <u>J. J. EDWIN FASSETT</u>		DATE SIGNED <u>1-4-56</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>1-8-56</u>	
NAME OF CEMETERY OR CREMATORY <u>Waugh Cemetery</u>		LOCATION (City, town, or county) (State) <u>Cambridge-Dor-Md.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>1-8-1956</u>		24. FUNERAL DIRECTOR ADDRESS <u>H.M. StClair, Jr.-High St-Camb., Md.</u>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



542

CERTIFICATE OF DEATH

Reg. Dist. No. 110

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Dorchester</u>	MARYLAND	STATE <u>Maryland</u>	COUNTY <u>Dorchester</u>
CITY (If outside corporate limits, write RURAL OR and give nearest town)	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town)	
<input checked="" type="checkbox"/> TOWN <u>Rhodesdale - Rural</u>	<u>9 years</u>	OR TOWN <u>Rhodesdale - Rural</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Eldorado</u>		STREET ADDRESS (If rural give location) <u>Eldorado</u>	
3. NAME OF DECEASED:		4. DATE (Month) (Day) (Year)	
(First) <u>George</u>	(Middle) <u>Wesley</u>	(Last) <u>Murphy</u>	
(Type or Print)		OF DEATH: <u>January 11 1956</u>	
5. SEX: <u>Male</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Married</u>	8. DATE OF BIRTH: <u>November 11, 1883</u>
9. AGE last birthday <u>72</u> yrs.		IF UNDER 1 YEAR: Months Days Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Retired Stationary Engineer</u>		10B. KIND OF BUSINESS OR INDUSTRY:	
11. BIRTHPLACE (State or foreign country): <u>Dorchester Co., Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME: <u>John N. Murphy</u>		14. MOTHER'S MAIDEN NAME: <u>Rebecca Rhodes</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES (Yes, no, or unk.) (If Yes, give war or dates of service) <u>Yes WW I</u>		16. SOCIAL SECURITY No. <u>089-05-8018</u>	
17. INFORMANT & ADDRESS: <u>Mrs. Florence F. Murphy, Rhodesdale, Md.</u>			
18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		<u>1 hour</u>	
(A) IMMEDIATE CAUSE <u>Coronary Occlusion</u>			
(B) ANTECEDENT CAUSE (S) <u>Coronary Disease</u>		<u>5 years +</u>	
(C) DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION: <u>Oct. 1955</u>		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21C. WHERE DID (City or town) (County) (State)		21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	
21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>Oct. 1955</u> , to <u>January 1956</u> , that I last saw the deceased alive on <u>January 9, 1956</u> , and that death occurred at <u>1 P. M.</u> from the causes and on the date stated above.			
SIGNATURE <u>W. C. Harrison</u>		DATE SIGNED <u>Jan. 13, 1956</u>	
M. D. <u>Hurlock, Maryland</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>Jan. 13, 1956</u>	
NAME OF CEMETERY OR CREMATORY <u>Eldorado Cemetery</u>		LOCATION (City, town, or county) (State) <u>Eldorado, Maryland</u>	
DATE REC'D BY LOCAL REGISTRAR <u>Jan 13 1956</u>		24. FUNERAL DIRECTOR ADDRESS <u>J.J. Frampton and Son, Federalsburg, Md.</u>	
REGISTRAR'S SIGNATURE <u>Charles W. Hastings</u>			

MARGIN RESERVED FOR BINDING

000000

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY Dorchester	MARYLAND	STATE Maryland	COUNTY Kent County
CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN Cambridge	LENGTH OF STAY (In this place) 1 mo & 24 das	CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN Chestertown, Md.	14-11-56
HOSPITAL OR INSTITUTION OR STREET ADDRESS Eastern Shore State Hospital		STREET ADDRESS (If rural, give location) ---	
3. NAME OF DECEASED: (Type or Print)		4. DATE OF DEATH	
(First) Martha	(Middle) Jane	(Last) Othoson	(Month) Jan. (Day) 9 (Year) 19 56
5. SEX: F	6. COLOR OR RACE: W	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): W	8. DATE OF BIRTH: 7-6-1866
9. AGE last birthday: 89 yrs.		IF UNDER 1 YEAR Months Days Hours Mln.	
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): None		10b. KIND OF BUSINESS OR INDUSTRY: --	11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.		13. FATHER'S NAME: William J. Hurlock	
14. MOTHER'S MAIDEN NAME: Mary Gordon		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) --	
16. SOCIAL SECURITY No.: --		17. INFORMANT & ADDRESS: Eastern Shore State Hospital Records	

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:		
<p>904.7</p> <p>Immediate cause</p> <p>(a) ... <i>Myocardial failure</i></p> <p>DUE TO</p> <p>Antecedent cause(s)</p> <p>Diseases or conditions, if any, giving rise to the above cause</p> <p>(b) ...</p> <p>DUE TO</p> <p>stating underlying cause last</p> <p>(c) ... <i>Fracture neck of femur</i></p>	<p><i>1 wk</i></p> <p><i>4 weeks</i></p>	
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.		

19a. DATE OF OPERATION:		19b. MAJOR FINDING OF OPERATION:		20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY <i>Highway</i>)		21c. (City or town) (County) (State) <i>Country</i> <i>Cal.</i> <i>Ill</i>	
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY <i>11-10-31-3P M.</i>		21e. INJURY OCCURRED While at Not while work <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? <i>Fell to floor</i>	

22. I hereby certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐, and find that death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐

SIGNATURE *John Mac H* M. D. CHIEF MEDICAL EXAMINER ☒ DATE SIGNED ☒ Jan. 9, 1956
DEPUTY MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAM. ☐

23. BURIAL, CREMATION, REMOVAL (Specify):	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
Burial	Jan. 12, 1956	Still Pond Cem.	Still Pond.	NH
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS	
Jan. 9, 1956	Edward Fellows John Mace Jr.	Edward Fellows.	Mellington, NH	

BUREAU V. S.

JAN 17 1908

RECEIVED

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INSTRUCTIONS

executed within 24 hours after death.

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this death certificate assembly should be detached for use as a burial transit permit.

VS A15C N55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

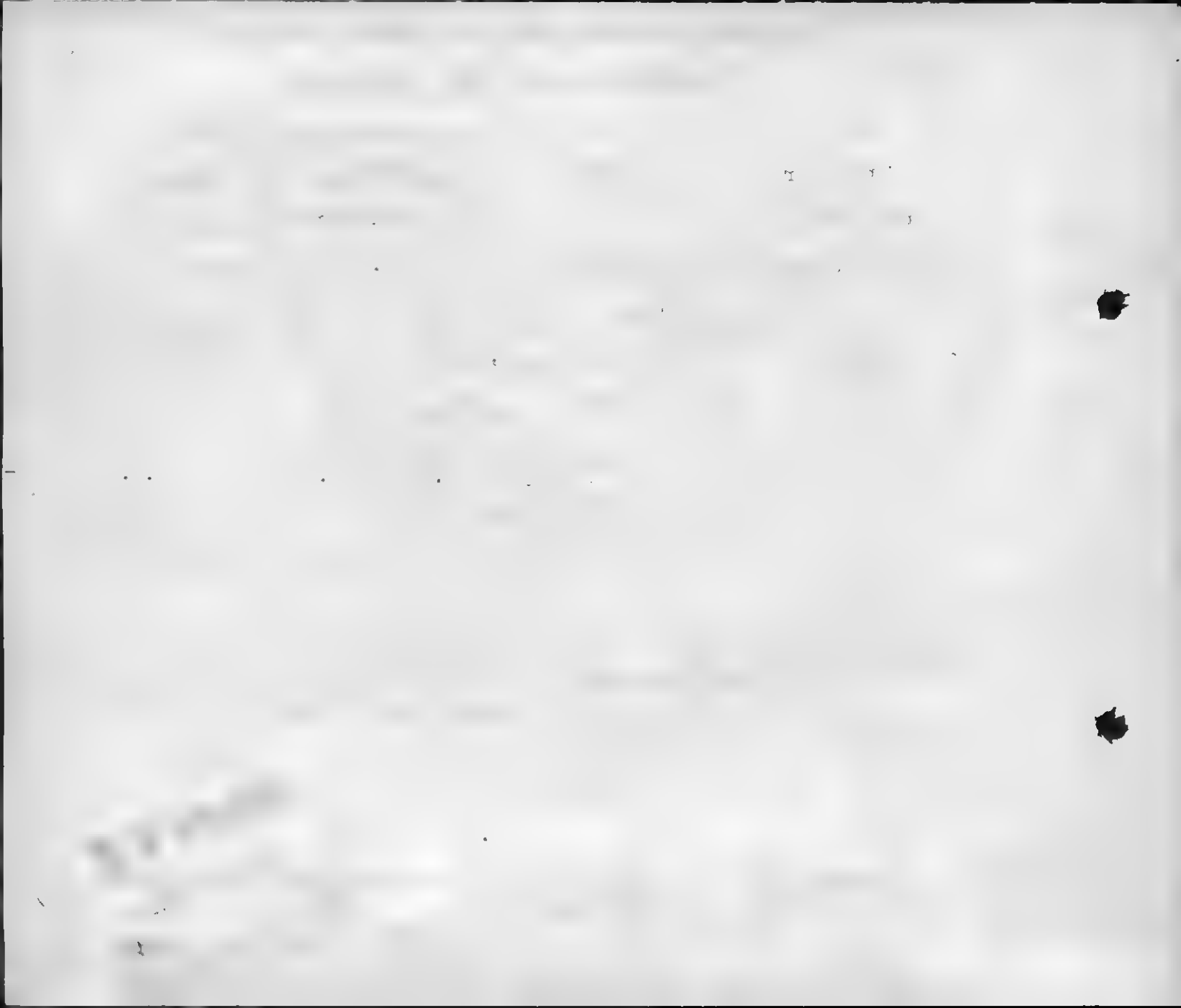
544

CERTIFICATE OF DEATH

00527

Reg. Dist. No. 116

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Dorchester</u>		STATE <u>Maryland</u>		COUNTY <u>Wicomico</u>			
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (In this place)		CITY OR TOWN		(If rural give location)	
TOWN <u>Cambridge</u>				TOWN <u>Salisbury</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS			
<u>16 Eastern Shore State Hospital</u>				<u>Rt. 3</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
<u>John William Parsons</u>				<u>Jan 21 19 56</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
<u>Male</u>	<u>White</u>	<u>Widowed</u>	<u>Dec 10 1883</u>	<u>72</u> YRS.	<u>72</u> Months	<u>21</u> Days	<u>56</u> Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>Farmer</u>		<u>on Own Farm</u>		<u>Maryland</u>		<u>US A</u>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>John Henry Parsons</u>				<u>Mary Ellen</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
				<u>Mr. Harold T. Parsons (Son) R.D. #3 Salisbury Hospital Records, Cambridge, Md</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
X IMMEDIATE CAUSE (A) <u>Broncho Pneumonia</u>				INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY?			
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Jan 3 56</u> , 19 <u>56</u> , to <u>Jan 21</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>Jan 21</u> , 19 <u>56</u> , and that death occurred at <u>9:55</u> P, from the causes and on the date stated above.							
SIGNATURE				ADDRESS (Street, city, town, state)		DATE SIGNED	
<u>John M. Dudgeon M.D.</u>				<u>Cambridge Maryland</u>		<u>Jan 21 56</u>	
23. BURIAL, CREMATION, REMOVAL (Specify)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Buried</u>		<u>Jan 24-56</u>		<u>Bethel Cem.</u>		<u>R.O. Salisbury Md</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
<u>John M. Dudgeon</u>		<u>John M. Dudgeon Jr.</u>		<u>Hollingsworth & Walter H. Hollingsworth</u>		<u>Salisbury Md</u>	
DATE							
<u>Jan 20 1956</u>							



PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

530

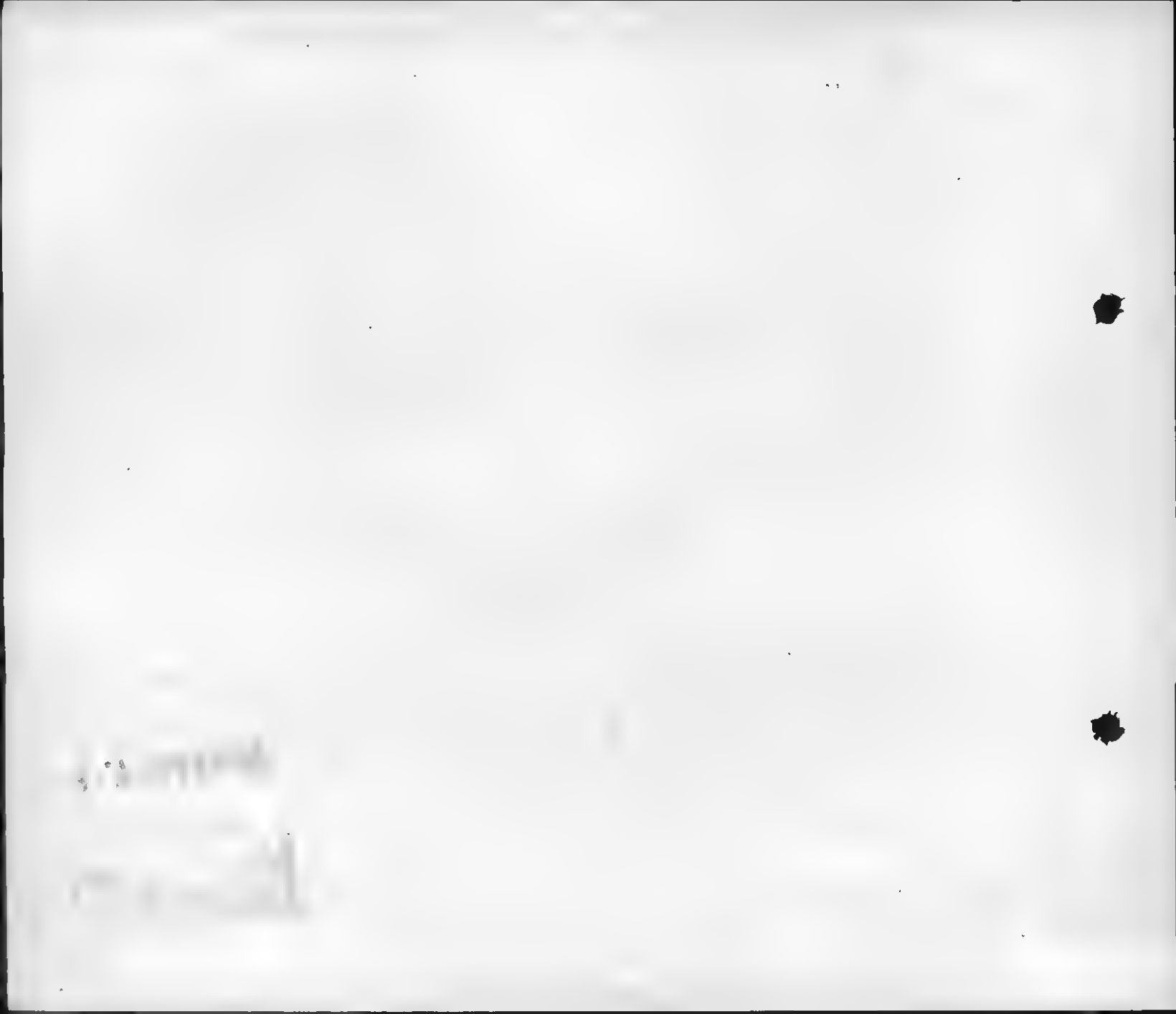
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00528

CERTIFICATE OF DEATH

Reg. Dist. No. 116

1. PLACE OF DEATH.		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Dorchester</u>	MARYLAND	STATE <u>Maryland</u>	COUNTY <u>Dorchester</u>
CITY (If outside corporate limits, write RURAL or and give nearest town) TOWN <u>Cambridge</u>	LENGTH OF STAY (In this place)	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Vienna</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Cambridge Md Hospital</u>		STREET ADDRESS (If rural give location) <u>RFD #1</u>	
3. NAME OF DECEASED: (First) (Middle) (Last) <u>Della</u> <u>Pinder</u>		4. DATE (Month) (Day) (Year) OF DEATH: <u>1</u> <u>22</u> <u>1956</u>	
5. SEX: <u>Female</u>	6. COLOR OR RACE: <u>Negro</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Married</u>	8. DATE OF BIRTH: <u>July 15, 1898</u>
9. AGE last birthday <u>57</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>Home</u>	11. BIRTHPLACE (State or foreign country): <u>Dorchester-Co-Md.</u>
13. FATHER'S NAME: <u>Joseph Stiles</u>		14. MOTHER'S MAIDEN NAME: <u>Georgianna Parker</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>219-07-7193</u>	17. INFORMANT & ADDRESS: <u>Minnie Young-Cambridge, Md.</u>
18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
IMMEDIATE CAUSE (A) <u>Confluent Bronchopneumonia Bilateral</u>			
ANTECEDENT CAUSE (S) DUE TO (B) <u>Gangrene right great toe</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) <u>Diabetes Mellitus</u>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION: <u>Jan 1955</u>		19B. MAJOR FINDINGS OF OPERATION: <u>Gangrene Left leg</u>	
20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21C. WHERE DID (City or town) (County) (State)		21D. HOW DID INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	
22. I hereby certify that I attended the deceased from <u>Oct 19, 1953</u> , to <u>Jan 22, 1956</u> , that I last saw the deceased alive on <u>Jan 22, 1956</u> , and that death occurred at <u>12:30</u> , from the causes and on the date stated above.			
SIGNATURE <u>J. Edwin Fassett</u>		ADDRESS <u>227 Pine St-Cambridge, Md.</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>1-26-56</u>	
NAME OF CEMETERY OR CREMATORY <u>Fork Neck Cemetery</u>		LOCATION (City, town, or county) (State) <u>Fork Neck, Md.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>Jan. 24, 1956</u>		24. FUNERAL DIRECTOR ADDRESS <u>H.M. St. Clair, Jr., Cambridge, Md.</u>	



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

545

00529

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist.

No. 116

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Dorchester</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Talbot</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits write RURAL and give nearest town)			
TOWN <u>Cambridge</u>		<u>11 mos. 15 days</u>		TOWN <u>Wye Mills</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Eastern Shore State Hospital</u>				STREET ADDRESS (If rural, give location) <u>---</u>			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE OF DEATH (Month) (Day) (Year)			
(Type or Print) <u>Donald</u> <u>--</u> <u>Rathell</u>				<u>January 4 1956</u>			
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:	9. AGE last birthday:	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<u>Male</u>	<u>White</u>	<u>Married</u>	<u>4-24-1894</u>	<u>61</u> yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY: <u>---</u>		11. BIRTHPLACE (State or foreign country): <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME: <u>Charles Rathell</u>				14. MOTHER'S MAIDEN NAME: <u>Minnie Donaldson</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>Unknown</u> <u>---</u>		16. SOCIAL SECURITY No.: <u>---</u>		17. INFORMANT & ADDRESS: <u>RECORDS: Eastern Shore State Hospital</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:						<u>Instant</u>	
<u>450.1</u> Immediate cause (a)..... DUE TO Antecedent cause(s) (b)..... Diseases or conditions, if any, giving rise to the above cause DUE TO stating underlying cause last (c)							
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Cerebral arteriosclerosis</u>						<u>?</u>	
19a. DATE OF OPERATION:		19b. MAJOR FINDING OF OPERATION:				20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY		21c. (City or town) (County) (State)			
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
SIGNATURE <u>[Signature]</u>		M. D. <u>[Signature]</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <u>1/4/56</u> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAM. <input type="checkbox"/>			
23. BURIAL, CREMATION, REMOVAL (Specify): <u>Burial</u>		DATE THEREOF <u>1-7-56</u>		NAME OF CEMETERY OR CREMATORY <u>Shenandoah Cemetery</u>		LOCATION (City, town, or county) (State) <u>Bellevue, Md.</u>	
DATE REC'D BY LOCAL REG. <u>Dec. 5, 1956</u>		REGISTRAR'S SIGNATURE <u>[Signature]</u>		24. FUNERAL DIRECTOR <u>W. Hampton Canoll</u>		ADDRESS <u>Easton, Md.</u>	

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INSTRUCTIONS

INSTRUCTIONS
 TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00530

531

CERTIFICATE OF DEATH

Reg. Dist. No. 116

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Dorchester</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Dorchester</u>	
CITY (If outside corporate limits, write RURAL or and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
13 TOWN <u>Cambridge</u>		4 Weeks		Cambridge Rural			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
27 Cambridge Md. Hospital				R.F.D. #3			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH (Month) (Day) (Year)			
ROLAND J. SEWARD				1 12 1956			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR IF UNDER 24 HRS.		
Male	White	W	3-30-1888	67 yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
Waterman		Seafood		Neck Dist Dor. Co., Md.		U.S.A.	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
James Seward				Ella Todd			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
No		None		Harvey E. Seward R.F.D. #3 Camb. Md.			
18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				2 days			
331 X IMMEDIATE CAUSE (A) Myocardial Failure							
ANTECEDENT CAUSE(S) DUE TO (B) Arteriosclerosis generalized							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) Cerebral Hemorrhage				5 Wks			
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. Diabetes Mellitus							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from....., 19....., to....., 19....., that I last saw the deceased alive on....., 19....., and that death occurred at.....M, from the causes and on the date stated above.							
SIGNATURE <u>[Signature]</u> M.D. <u>Cambridge Md</u>				DATE SIGNED <u>1/16/56</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
Burial		1-15-56		Dorchester Memorial park		Cambridge Dorchester Md.	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
DATE <u>Jan. 15, 1956</u>		<u>[Signature]</u>		<u>[Signature]</u>		LeCompte Funeral Service Cambridge, Md.	



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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

546

CERTIFICATE OF DEATH

00531

Reg. Dist. No. 116

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Dorchester</u>		STATE <u>Maryland</u> COUNTY <u>Baltimore</u>		CITY (If outside corporate limits, write RURAL and give nearest town)		CITY (If outside corporate limits, write RURAL and give nearest town)	
TOWN <u>Cambridge</u>		LENGTH OF STAY (In this place) <u>7/29/1944</u>		TOWN <u>Pikesville</u>		TOWN	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Eastern Shore State Hospital</u>				STREET ADDRESS <u>110 Reisterstown Road</u>			
3. NAME OF DECEASED (First) <u>Donald</u> (Middle) <u>C.</u> (Last) <u>Stoppenbach</u>				4. DATE OF DEATH (Month) <u>Jan.</u> (Day) <u>1</u> (Year) <u>56</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>Feb. 11, 1893</u>	9. AGE last birthday <u>62</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Electrical Engineer</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Unknown</u>		11. BIRTHPLACE (State or foreign country) <u>Oregon</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>Theodore N. Stoppenbach</u>				14. MOTHER'S MAIDEN NAME <u>Marie L. Bishop</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? <u>Unknown</u> (If Yes, give war or dates of service)			16. SOCIAL SECURITY NO. <u>Unknown</u>		17. INFORMANT & ADDRESS <u>Eastern Shore State Hospital Records</u>		
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
IMMEDIATE CAUSE (A) <u>Lobar Pneumonia</u>						INTERVAL BETWEEN ONSET AND DEATH <u>5 days</u>	
ANTECEDENT CAUSE(S) DUE TO DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (B) <u> </u>							
DUE TO (C) <u> </u>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Psychosis with Syphilitic Meningo-encephalitis (General Paresis)</u>						<u>12 years plus</u>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <u> </u> <u> </u> <u> </u> <u> </u>		21a. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>12/1</u> , 19 <u>51</u> , to <u>1/1</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>12/31</u> , 1955, and that death occurred at <u>12:02 A.M.</u> , from the causes and on the date stated above.							
SIGNATURE <u>Robert H. Reddick</u>				ADDRESS (Street, city, town, state) <u>M.D. State Hospital, Cambridge, Md.</u>		DATE SIGNED <u>1/1/56</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>1-2-1956</u>		NAME OF CEMETERY OR CREMATORY <u>St. Anne's Cem.</u>		LOCATION (City, town, or county) (State) <u>Annapolis Md.</u>	
24. REC'D BY REGISTRAR <u>John Macer Jr.</u>		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE <u>John H. Taylor</u>		ADDRESS <u>Don Annapolis Md.</u>	
DATE <u>Jan. 3, 1955</u>							

3 A. 000000

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INSTRUCTIONS

THE ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 11 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

V5 AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

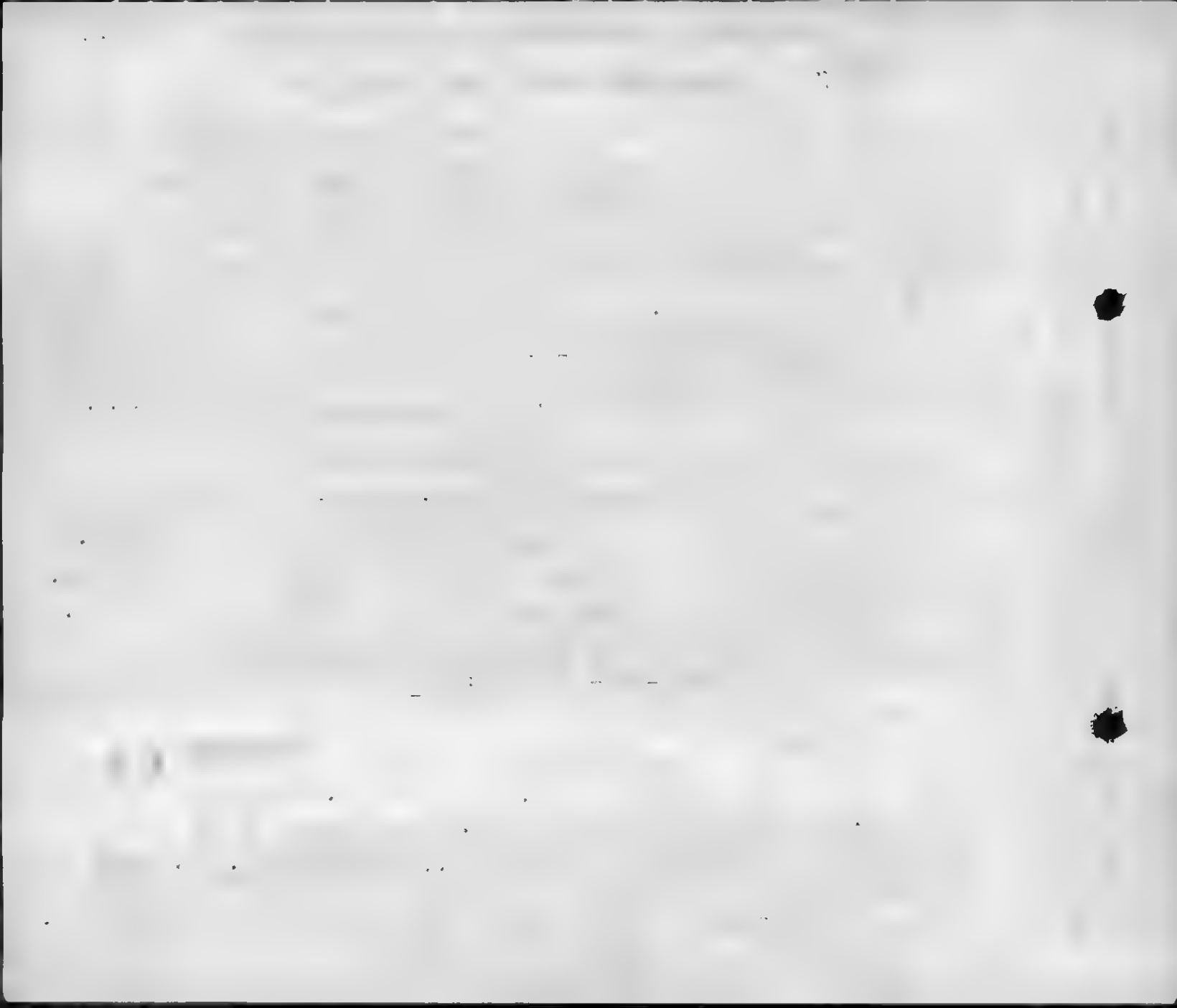
00532

532

CERTIFICATE OF DEATH

Reg. Dist. No. 116

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Dorchester</u>		STATE <u>Maryland</u>		COUNTY <u>Dorchester</u>			
CITY <u>Cambridge</u> (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (In this place) <u>5 Weeks</u>		CITY <u>Cambridge</u> (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Cambridge</u>				STREET ADDRESS <u>5 Peachblossom Ave.</u>		(If rural give location)	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Cambridge Maryland Hospital</u>							
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>Floyd</u>		(Middle) <u>W.</u>		(Last) <u>TODD</u>		(Month) <u>Jan</u> (Day) <u>4</u> (Year) <u>1956</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>7-11-1879</u>	9. AGE last birthday <u>76</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Machinist</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Construction Co.</u>		11. BIRTHPLACE (State or foreign country) <u>Toddville, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Riley Todd</u>				14. MOTHER'S MAIDEN NAME <u>not Known</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT & ADDRESS <u>Mrs. Floyd W. Todd 5 Peachblossom Ave</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
IMMEDIATE CAUSE (A) <u>CORONARY THROMBOSIS</u>				INTERVAL BETWEEN ONSET AND DEATH <u>1 wk.</u>			
ANTECEDENT CAUSE(S) DUE TO (B) <u>URETHRAL STRICTURE</u>				<u>10 yrs.</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>PYELO NEPHROSIS</u>				<u>4yrs.</u>			
11. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>HYPERTENSIVE CARDIO VASCULAR DISEASE AND CHRONIC OSTEO ARTHRITIS</u>							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION <u>RECENT MYOCARDIAL INFARCTION-URETHRAL STRICTURE</u>		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Sep. 51</u> , 19 <u>51</u> , to <u>Jan. 4</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>Jan. 4</u> , 19 <u>56</u> , and that death occurred at <u>5 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>W. Race St.</u>				DATE SIGNED <u>1-9-56</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>1-7-56</u>		NAME OF CEMETERY OR CREMATORY <u>Dorchester Memorial Park</u>		LOCATION (City, town, or county) (State) <u>Cambridge Dorchester Md.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <u>W. Race St.</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>LeCompte Funeral Service Cambridge, Md.</u>			
DATE <u>Jan. 7, 1956</u>							



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547

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Dorchester</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Wicomico</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Cambridge</u>		<u>mos. 3 das.</u>		TOWN <u>Salisbury</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Eastern Shore State Hospital</u>				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED (Type or Print) <u>Norena</u> (First) <u>V.</u> (Middle) <u>Toomey</u> (Last)				4. DATE OF DEATH (Month) <u>Jan.</u> (Day) <u>2</u> (Year) <u>1956</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>2-10-87</u>	9. AGE last birthday <u>68</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Librarian</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>-</u>		11. BIRTHPLACE (State or foreign country) <u>New Jersey</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Timothy J. Foley</u>				14. MOTHER'S MAIDEN NAME <u>Honore Agnes Barry</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>-</u> (If Yes, give war or dates of service) <u>-</u>		16. SOCIAL SECURITY NO. <u>-</u>		17. INFORMANT & ADDRESS <u>Eastern Shore State Hospital Records (and)</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION <u>Mrs. Jane Delano (Sister)</u> <u>103 East St. Delmar, Md.</u> INTERVAL BETWEEN ONSET AND DEATH <u>sev. Years</u>			
IMMEDIATE CAUSE (A) <u>Cancer of the Uterus</u>							
ANTECEDENT CAUSE(S) DUE TO (B) <u>-</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>-</u>							
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDIT ON CAUSING DEATH. <u>Psychosis with Cerebral Arteriosclerosis</u>							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21a. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>April 30, 1955</u>, to <u>Jan. 2</u>, 1956, that I last saw the deceased alive on <u>Jan. 2</u>, 1956, and that death occurred at <u>7:15 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Simon Virkulis M.D.</u>				ADDRESS (Street, city, town, state) <u>M.D. E.S.S. Hospital, Cambridge, Maryland</u>		DATE SIGNED <u>1-3-56</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>Jan. 5th, 1956</u>		NAME OF CEMETERY OR CREMATORY <u>Parsons Cemetery</u>		LOCATION (City, town, or county) <u>Salisbury Maryland</u>	
24. REC'D BY REGISTRAR <u>John Mace, Jr.</u>		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE <u>Holloway & Co.</u>		ADDRESS <u>Salisbury Md.</u>	

INSTRUCTIONS

THE ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VE AISC 1-58 10M

RECEIVED

JAN 5 1956

RECEIVED

INSTRUCTIONS

1 TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

2 TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

00534

548

CERTIFICATE OF DEATH

Reg. Dist. No. 116

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Dorchester</u>		STATE <u>Maryland</u> COUNTY <u>Georgetown</u>		CITY <u>Perryville</u>		(If rural give location)	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY <u>9/30/54</u>		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Cambridge</u>				TOWN			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Eastern Shore State Hospital</u>				STREET ADDRESS			
3. NAME OF DECEASED (Type or Print) <u>Hallah L. Van Doren</u>				4. DATE OF DEATH (Month) <u>Jan</u> (Day) <u>28</u> (Year) <u>1956</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Single</u>	8. DATE OF BIRTH <u>Jan 22, 1875</u>	9. AGE last birthday <u>81</u> yrs.	10. IF UNDER 1 YEAR (Month) <u>28</u> (Day) <u>19</u> (Hour) <u>56</u> (Min.)		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>New Jersey</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Augustus Van Doren</u>				14. MOTHER'S MAIDEN NAME <u>Hannah Foree</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>		17. INFORMANT & ADDRESS <u>Eastern Shore State Hospital Records</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
IMMEDIATE CAUSE (A) <u>Bronchopneumonia</u>				INTERVAL BETWEEN ONSET AND DEATH <u>5 days</u>			
ANTECEDENT CAUSE(S) DUE TO (B)							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Senile Psychosis</u>							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office, etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>9/30</u>, 19<u>54</u>, to <u>1/28</u>, 19<u>56</u>, that I last saw the deceased alive on <u>1/27</u>, 19<u>56</u>, and that death occurred at <u>2:15 A.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Robert H. Reddick</u> M.D. <u>State Hospital, Cambridge, Md.</u>				DATE SIGNED <u>1/28/56</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Cremation</u>		DATE THEREOF <u>1/28/56</u>		NAME OF CEMETERY OR CREMATORY <u>Green mount Cemetary</u>		LOCATION (City, town, county) (State) <u>Baltimore, Maryland.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <u>[Signature]</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Le Compte Funeral Service, Cambridge, Md.</u>			
DATE <u>Jan 28 '56</u>							

RECEIVED
FEB 1

549 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 116

Items 11, 13, 14 Film G192 1-31-56 et

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Dorchester</u>	MARYLAND	STATE <u>Maryland</u> COUNTY <u>Worcester</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town)	
TOWN <u>rural Cambridge</u>		TOWN <u>Ironshire</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Eastern Shore State Hospital</u>		STREET ADDRESS (If rural give location)	

3. NAME OF DECEASED:		4. DATE OF DEATH	
(First) <u>George</u>	(Middle) <u>Warren</u>	(Month) <u>Jan</u>	(Day) <u>21</u> (Year) <u>1956</u>
5. SEX: <u>M</u>	6. COLOR OR RACE: <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Single</u>	8. DATE OF BIRTH: <u>Dec 19 1877</u>
9. AGE last birthday: <u>78</u> yrs.		10. BIRTHPLACE (State or foreign country): <u>Berlin, Md.</u>	11. CITIZEN OF WHAT COUNTRY: <u>U.S.A.</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Clark</u>		10b. KIND OF BUSINESS OR INDUSTRY:	

13. FATHER'S NAME: <u>Albert Warren</u>	14. MOTHER'S MAIDEN NAME: <u>Mary Rayne</u>
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)	16. SOCIAL SECURITY NO.
17. INFORMANT & ADDRESS: <u>ES. State Hosp. Hospital Records Cambridge</u>	

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
IMMEDIATE CAUSE	(A) <u>Cerebral Haemorrhage</u>	<u>Unk</u>
ANTECEDENT CAUSE (S)	DUE TO	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE, STATING UNDERLYING CAUSE LAST.	(B) <u>General Arteriosclerosis</u>	<u>Unk</u>
	DUE TO	
	(C)	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.		

19a. DATE OF OPERATION:	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	21c. WHERE DID (City or town) (County) (State)
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY	21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Oct 6, 1956, to Jan 21, 1956, that I last saw the deceased alive on Jan 21, 1956, and that death occurred at 11:35 AM, from the causes and on the date stated above.

SIGNATURE <u>Thomas J. Dredge</u>	DATE SIGNED <u>Jan 21 '56</u>
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>	DATE THEREOF <u>1-23-56</u>
NAME OF CEMETERY OR CREMATORY <u>European</u>	LOCATION (City, town, or county) (State) <u>Berlin Md</u>
DATE REC'D BY LOCAL REGISTRAR <u>Jan 23, 1966</u>	REGISTRAR'S SIGNATURE <u>John H. H. N. D.</u>
24. FUNERAL DIRECTOR <u>Anna L. L. L.</u>	ADDRESS <u>Berlin Md</u>

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

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MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

00536

533

CERTIFICATE OF DEATH

Reg. Dist. No.

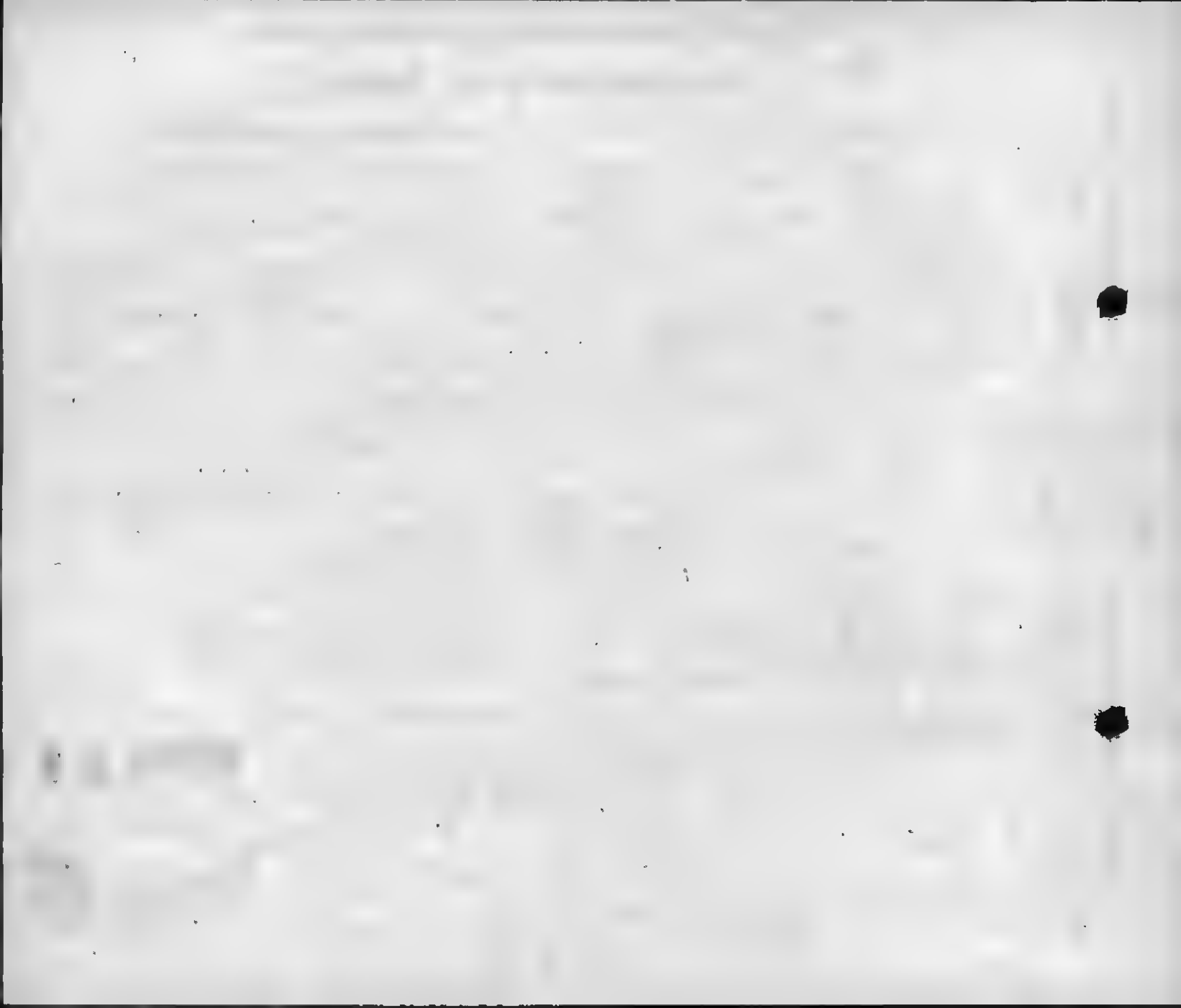
1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Dorchester</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Dorchester</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Cambridge</u>		<u>40 years</u>		TOWN <u>Cambridge R.D. 1</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Cambridge-Maryland Hospital</u>				STREET ADDRESS <u>Rural</u> (If rural give location)			
3. NAME OF (First) (Middle) (Last)				4. DATE OF DEATH (Month) (Day) (Year)			
<u>Fred</u> <u>Weber</u>				<u>Jan. 19</u> <u>1956</u> <u>19</u>			
5. SEX		6. COLOR OR RACE		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)		8. DATE OF BIRTH	
<u>Male</u>		<u>White</u>		<u>Married</u>		<u>Jan. 13, 1872</u>	
						9. AGE last birthday <u>84</u> yrs.	
						IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Farmer Self Employed</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
						<u>Baltimore</u>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>Fred Weber</u>				<u>Wilhelmina Muth</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT & ADDRESS <u>R.F.D. 2</u> <u>Elizabeth M. Weber, Cambridge, Md.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
IMMEDIATE CAUSE (A) <u>BRONCHITIS</u>				INTERVAL BETWEEN ONSET AND DEATH <u>7 DAYS</u>			
ANTECEDENT CAUSE(S) DUE TO (B) <u>BRONCHIECTASIS</u>				<u>20 YEARS</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>OLD RHEUMATIC HEART DISEASE</u>				<u>?</u>			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>14 JAN 19 56</u> , to <u>19 JAN 19 56</u> , that I last saw the deceased alive on <u>19 JAN 19 56</u> , and that death occurred at <u>8:45 AM</u> , from the causes and on the date stated above.							
SIGNATURE <u>Walter E. Gurnley, Jr.</u>				DATE SIGNED <u>20 JAN 56</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>				DATE THEREOF <u>Jan 23, 1956</u>		NAME OF CEMETERY OR CREMATORY <u>Oak Lawn Cemetery</u>	
						LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <u>John H. K. Bennett</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Walter R. Thomas</u>		ADDRESS <u>Cambridge, Md.</u>	
DATE <u>Jan 23, 1956</u>							

INSTRUCTIONS

TO ATTENDING PHYSICIAN: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M



1

INSTRUCTIONS

1. TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

2. TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

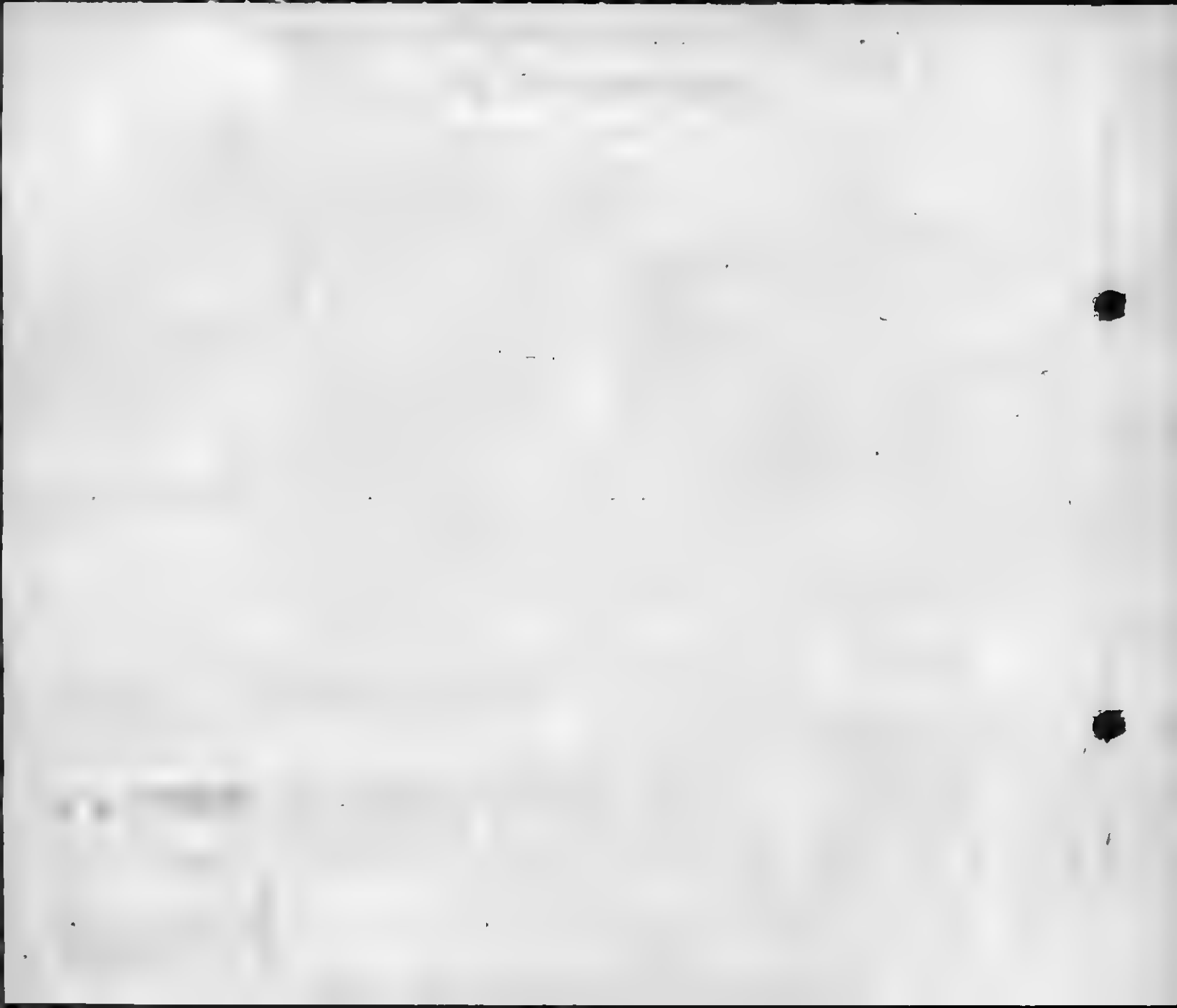
00537

534

CERTIFICATE OF DEATH

Reg. Dist. No. 16

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Dorchester</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Dorchester</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN			
13 TOWN <u>Cambridge</u>		8 Weeks		Cambridge			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
17 Cambridge Md. Hospital				407 Choptank Ave			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) (Middle) (Last)				(Month) (Day) (Year)			
DORIS BRANNOCK WHEATLEY				1 13 1956			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
Female	White	M	3-18-1924	31 yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
Housewife				Woolfords, Maryland		U.S.A.	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
John A. Brannock				Lula Fitzhugh			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
No		217-16-9353		Howard T. Wheatley Cambridge, Md.			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
176X IMMEDIATE CAUSE (A) Generalized carcinomatosis						6 months	
ANTECEDENT CAUSE(S) DUE TO (B) Carcinoma (squamous cell) of vagina						2 years	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
Dec 1954		Carcinoma of vagina with metastasis					
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from Nov. 1954, to Jan. 13, 1956, that I last saw the deceased alive on Jan. 12, 1956, and that death occurred at 4 A.M. from the causes and on the date stated above.							
SIGNATURE <u>Lewis M. Burdette</u>				ADDRESS (Street, city, town, state) <u>City Office Bldg., Cambridge, Md.</u>		DATE SIGNED <u>Jan 15, 1956</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
Burial		1-15-56		Dorchester Mem. Park		Cambridge Dor. Md.	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
DATE <u>Jan 15, 1956</u>		<u>John M. R. E.</u>		<u>LeCompte Funeral Service</u>		Cambridge, Md.	



00538

Reg. Dist.

535
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 21 Film 6192 2-17-56

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

No.

1. PLACE OF DEATH:

COUNTY DORCHESTER

MARYLAND

CITY (If outside corporate limits, write RURAL
OR and give nearest town)TOWN CAMBRIDGELENGTH OF STAY
(in this place)HOSPITAL OR
INSTITUTION OR
STREET ADDRESSCAMBRIDGE CREEK

2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE MARYLAND COUNTY Dorchester

CITY (If outside corporate limits write RURAL and give nearest town)

TOWN AIRYSTREET
ADDRESS

(If rural, give location)

NONE3. NAME OF
DECEASED:

(Type or Print)

(First)

(Middle)

(Last)

ISAACWILSON4. DATE
OF
DEATH

(Month)

(Day)

(Year)

1231956

5. SEX:

M6. COLOR OR
RACE:C7. SINGLE, MARRIED,
WIDOWED, DIVORCED,
(Specify):SINGLE

8. DATE OF BIRTH:

4-17-1906

9. AGE last birthday:

49 yrs.

IF UNDER 1 YEAR

IF UNDER 24 HRS.

Months

Days

Hours

Min.

10a. USUAL OCCUPATION (Give kind of
work done during most of work life,
even if retired):WATERMAN10b. KIND OF BUSINESS OR
INDUSTRY:NONE

11. BIRTHPLACE (State or foreign country):

MARYLAND; DOB12. CITIZEN OF WHAT
COUNTRY?U.S.A.

13. FATHER'S NAME:

ISAACWILSON

14. MOTHER'S MAIDEN NAME:

UNKNOWN15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unk.) (If Yes, give war or dates of
service)*No

16. SOCIAL SECURITY No.:

217-10-8191

17. INFORMANT & ADDRESS:

LAURAADAMES

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

Immediate cause.

(a)

DUE TO

DROWNING

Antecedent cause(s)

Diseases or conditions, if any.

(b)

giving rise to the above cause

DUE TO

stating underlying cause last

(c)

INTERVAL BETWEEN
ONSET AND DEATH
IMMED.II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING DEATH.

19a. DATE OF OPERATION:

19b. MAJOR FINDING OF OPERATION:

20. AUTOPSY?

Yes ☐ No ☒21a. EXTERNAL CAUSE WAS
PRIMARY ☐ OR CONTRIBUTING ☐
CAUSE OF DEATH.21b. PLACE (Home, farm, factory,
OF street, office, bldg., etc.)
INJURY

21c. (City or town)

(County)

(State)

21d. TIME (Month) (Day) (Year) (Hour)
OF INJURYFound 1/30/56M.21e. INJURY OCCURRED
While at Not while
work ☐ at work ☐21f. HOW DID INJURY OCCUR? fell for work on dredge
boat at 11:30 P.M. 1/22/56. Circumstances of
his falling into creek unknown.22. I hereby certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐, and
find that death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined cause ☐.

SIGNATURE

Alfred R. Maryanor

CHIEF MEDICAL EXAMINER

DATE SIGNED

DEPUTY MEDICAL EXAMINER

1/31/56

M. D.

ASSISTANT MEDICAL EXAM.

23. BURIAL, CREMATION,
REMOVAL (Specify):

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

Feb. 1, 1956JohnMcC. R. E.JohnDorchesterMd.

REG.

BUREAU V. 2

FEB 6 1956

RECEIVED

Handwritten signatures and initials at the bottom left.

Handwritten text at the bottom center.

Small handwritten text at the bottom right.

ISAC Wilson
215-10-8181 LARRY ADAMCZ

UNKNOWN

WATERMAN HOME MARPLANDSON U.S.A.

215-10-8181

Handwritten text in the upper middle section.

Handwritten text at the top left.

1
INSTRUCTIONS
TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.
VS A13C 1-55 10M

536

CERTIFICATE OF DEATH

00539

Reg. Dist. No. 116

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY Dorchester		STATE Maryland		COUNTY Dor.			
CITY (If outside corporate limits, write RURAL OR end give nearest town) Cambridge		LENGTH OF STAY (In this place) entire life		CITY (If outside corporate limits, write RURAL and give nearest town) Cambridge			
HOSPITAL OR INSTITUTION OR STREET ADDRESS Cambridge-Maryland Hospital		STREET ADDRESS (If rural give location) R.F.D. 1					
3. NAME OF DECEASED (First) (Middle) (Last) Christopher Woodward				4. DATE OF DEATH (Month) (Day) (Year) 1 - 3 - 1956			
5. SEX Male	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Single	8. DATE OF BIRTH 1-1-56	9. AGE last birthday 12 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Cambridge		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Charles Woodward				14. MOTHER'S MAIDEN NAME Joan Wood			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) no		16. SOCIAL SECURITY NO. none		17. INFORMANT & ADDRESS Charles Woodward, R.D. 1 Cambridge, Md.			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
776x IMMEDIATE CAUSE (A) Prematurity						36 hrs	
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE DUE TO							
STATING UNDERLYING CAUSE LAST. (C)							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (M. el work) <input type="checkbox"/> Not while el work <input type="checkbox"/>		21e. INJURY OCCURRED While el work <input type="checkbox"/> Not while el work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 1-1-1956 , to 1-3-1956 , that I last saw the deceased alive on 1-3-1956 , and that death occurred at 4:30 M. from the causes and on the date stated above.							
SIGNATURE [Signature]				ADDRESS (Street, city, town, state) Cambridge		DATE SIGNED 1-4-56	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) burial		DATE THEREOF Jan. 3, 1956		NAME OF CEMETERY OR CREMATORY Catholic Cemetery, Secretary, Maryland		LOCATION (City, town, or county) (State)	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE [Signature]		25. FUNERAL DIRECTOR'S SIGNATURE [Signature]		ADDRESS Cambridge, Md.	

2087243281

CERTIFICATE OF DEATH

382

DATE OF DEATH

A. J. JAMES

WHITE

MALE

AGE 45

CAUSE OF DEATH

HEART DISEASE

DATE OF DEATH

JAN 18 1928

PLACE OF DEATH

HOME

SIGNATURE OF PHYSICIAN

J. J. JAMES

DATE OF DEATH

JAN 18 1928

PLACE OF DEATH

HOME

SIGNATURE OF PHYSICIAN

J. J. JAMES

DATE OF DEATH

JAN 18 1928

PLACE OF DEATH

HOME

SIGNATURE OF PHYSICIAN

J. J. JAMES

DATE OF DEATH

JAN 18 1928

PLACE OF DEATH

HOME

SIGNATURE OF PHYSICIAN

J. J. JAMES

DATE OF DEATH

JAN 18 1928

PLACE OF DEATH

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SIGNATURE OF PHYSICIAN

J. J. JAMES

DATE OF DEATH

JAN 18 1928

PLACE OF DEATH

HOME

SIGNATURE OF PHYSICIAN

J. J. JAMES

DATE OF DEATH

JAN 18 1928

BUREAU V. S.

JAN 18 1928

RECEIVED